ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Alternatives for Adults with Physical Disabilities Waiver**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal APDWVR-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.000	7-15-09	211.000	4-1-12
213.200	7-15-09	213.200	4-1-12
213.300	7-15-09	213.300	4-1-12

Explanation of Updates

Sections 211.000, 213.200 and 213.300 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

211.000 Scope 4-1-12

The Arkansas Medicaid Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to individuals with disabilities age 21 through 64 who have received a determination of physical disability by SSI/SSA or DHS Medical Review Team (MRT) and who, without the provision of home and community-based services, would require a nursing facility (NF) level of care. The participant's income must be equal to or less than 300% of the SSI eligibility limit.

The community-based services offered through the Alternatives for Adults with Physical Disabilities Home and Community-Based Waiver, described herein as Alternatives, are as follows:

1. Environmental Accessibility Adaptations/Adaptive Equipment
2. Agency Attendant Care – Consumer-Directed
3. Agency Attendant Care – Traditional and Consumer-Directed
4. Case Management/Counseling Support

These services are designed to maintain Medicaid eligible beneficiaries at home in order to preclude or postpone institutionalization of the individual.

Please note that in accordance with 42 CFR 441.301 (b)(l)(ii), alternatives services are not covered for inpatients of nursing facilities, hospitals or other inpatient institutions.

213.200 Attendant Care Service 4-1-12

Attendant Care Service is assistance to a medically stable individual with a physical disability in accomplishing tasks of daily living that the participant is unable to complete independently. Assistance may vary from actually doing a task for the participant, to assisting the participant to perform the task or to providing safety support while the participant performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished. Housekeeping activities as described above may not exceed 20% of the Attendant's overall time worked as authorized on the waiver plan of care. Attendant Care Services may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care services, accompanying a participant to assist with shopping, errands, etc.

A. If Attendant Care Service is selected, a consumer-directed approach will be used in the provision of Attendant Care services. The participant is free to select the tasks to be performed and when these tasks will be accomplished. Each participant who elects to receive Attendant Care Services must agree to and be capable of recruiting, hiring, training, managing and terminating Attendants. The participant must also monitor Attendant Service timesheets and approve payment to the Attendant for services provided by signing the timesheets.

   Participants who can comprehend the rights and accept the responsibilities of consumer-directed care may wish to have Alternatives Attendant Care Services included on their plan of care. The participant's plan of care will be submitted to the attending physician for his or her review and approval.

B. The Evaluation of Need for Nursing Home Care Form (DHS-703) completed by the DAAS Rehab Counselor or RN for each Alternatives Waiver applicant will contain information relative to the participant's functional, social and environmental situation.

C To aid in the Attendant Care recruitment process, participants will be apprised of the minimum qualifications set forth for provider certification (See Section 213.220) and the Medicaid enrollment and reimbursement process. The participant will be instructed to notify the DAAS Rehab Counselor or RN when an attendant has been recruited. The DAAS Waiver Counselor or RN will facilitate the development of a formal service

agreement between the participant and the Attendant, using the form AAS-9512, Attendant Care Service Agreement. Instructions are provided with the Attendant Care packet.

D When the AAS-9512, Attendant Care Service Agreement, is finalized, the Attendant will apply for DAAS certification and Medicaid provider enrollment. The DAAS Rehab Counselor or RN or designee will assist as needed to expedite this process. As an enrolled Medicaid provider, the attendant will be responsible for all applicable Medicaid participation requirements, including claims submission.

Service agreements and required tax documents do not transfer from one waiver client to another or from one waiver provider to another. All service agreements and tax forms are specific to each employer and employee working arrangement.

E. Refer to Section 241.100 of this manual for the procedure code to be used with filing claims for this service.

213.300 Agency Attendant Care 4-1-12

Agency Attendant Care services are the provision of assistance to a medically stable individual with a physical disability to accomplish those tasks of daily living that the individual is unable to complete independently and that are performed by an Attendant Care employee hired by an agency selected by the waiver participant. Assistance may vary from actually doing a task for the individual to assisting the individual with the task or to providing safety support while the individual performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished. Housekeeping activities as described above may not exceed 20% of the attendant's overall time worked as authorized on the waiver plan of care. Agency Attendant Care Services may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care Services while accompanying a participant to assist with shopping, errands, etc.

If Agency Attendant Care Services are selected, participants may choose to have their services provided through an agency that is certified by the Division of Aging and Adult Services to provide Agency Attendant Care. When the participant chooses to have Attendant Care Services provided through an agency, the participant may choose one of two agency Attendant Care Services options: 1) participant/co-employer where the participant functions as the co-employer (managing employer) of employees hired by an Attendant Care agency, and the agency manages the hiring and fiscal responsibilities or 2) a traditional agency model for Attendant Care Services where the agency performs both the managing of the Attendant Care employee and hiring and fiscal responsibilities.

A. If the participant chooses the participant/co-employer (managing employer) option, the participant performs duties such as determining the Attendants' duties consistent with the service specification in the approved plan of care, scheduling Attendants, orienting and instructing Attendants' duties, supervising Attendants, evaluating Attendants' performance, verifying time worked by Attendants, approving time sheets and discharging Attendants from providing services. The participant may also recruit prospective Attendant Care Aides who are then referred to the agency for consideration for hiring. The agency chosen by the participant to provide Attendant Care Services is the employer of participant-selected/recruited staff and performs necessary payroll and human resources functions.

If the participant chooses the traditional agency model option, the agency performs both the responsibilities of managing the Attendant Care employee and the hiring and fiscal responsibilities. Participants who decide to have their Attendant Care services provided through an agency may wish to have Alternatives Agency Attendant Care Services included on their plan of care. The participant's plan of care is submitted to the participant's attending physician for his or her review and approval.

B. The Evaluation of Need for Nursing Home Care Form (DHS-703) completed by the DAAS Rehab Counselor or RN for each Alternatives Waiver applicant contains information relative to the participant's functional, social and environmental situation.

C. The Attendant Care agency must staff and notify the DAAS Rehab Counselor or RN via the DAAS-9510, according to established program policy, when an Attendant has been assigned to a waiver participant. In addition, prior to Medicaid reimbursement, an agency must secure a service agreement, signed by the agency representative and the waiver participant. This agreement must be sent to the DAAS Central Office prior to claims submission.

D. As an enrolled Medicaid provider, the Attendant Care agency is responsible for all applicable Medicaid participation requirements, including claims submission.

E. Refer to Section 244.100 of this manual for the procedure code to be used when filing claims for this service.

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Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Ambulatory Surgical Center**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal ASC-2-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
216.500	10-13-03	216.500	4-1-12

Explanation of Updates

Section 216.500 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

216.500 Acknowledgement Statement for Hysterectomies and Sterilization Consent Form 4-1-12

The acknowledgement statement for hysterectomies must be signed by the patient or a representative and the sterilization consent form must be signed by the patient. For beneficiaries with physical disabilities, these required statements must be signed by the patient. If the patient signs with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed with an "X," such as, stroke, paralysis, legally blind, etc. This procedure is to be used for patients who are not mentally impaired.

For hysterectomies for the mentally incompetent, the acknowledgement of sterility statement is required. A guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition and the acknowledgement statement must be attached to the claim. Sterilization procedures for birth control purposes are not covered for the mentally incompetent.

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TO: **Arkansas Medicaid Health Care Providers – DDS Alternative Community Services (ACS) Waiver**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal DDSACS-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
211.000	3-1-10	211.000	4-1-12
213.100	3-1-10	213.100	4-1-12
214.000	3-1-10	214.000	4-1-12
230.300	3-1-10	230.300	4-1-12

Explanation of Updates

Sections 211.000, 213.100, 214.000 and 230.300 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

211.000 Scope 4-1-12

The Medicaid program offers certain home and community based services (HCBS) as an alternative to institutionalization. These services are available to eligible beneficiaries who are individuals with a developmental disability who would otherwise require an intermediate care facility for the mentally retarded (ICF/MR) level of care. This waiver does not provide education or therapy services.

The purpose of the ACS waiver is to support beneficiaries of all ages who have a developmental disability, meet the institutional level of care and require waiver support services to live in the community and thus preventing institutionalization.

The goal is to create a flexible array of services that will allow people to reach their maximum potential in decision making, employment and community integration; thus giving their lives the meaning and value they choose.

The objectives are as follows:

A. To transition eligible persons who choose the waiver option from residential facilities into the community

B. To provide priority services to persons who meet the pervasive level of service (imminent danger and requiring supports 24 hours a day, seven days a week)

C. To enhance and maintain community living for all persons participating in the waiver program

DDS is responsible for day-to-day operation of the waiver. All waiver services are accessed through DDS Adult Services, DDS Children's Services or the ICF/MR services intake and referral staff.

All ACS waiver services must be prior authorized by DDS. All services must be delivered based on the approved person centered service plan.

Waiver services will not be furnished to persons while they are inpatients of a hospital, nursing facility (NF) or ICF/MR unless payment to the hospital, NF or ICF/MR is being made through private pay or private insurance.

A person may be placed in abeyance in three-month increments (with status report every month) for up to 12 months when the following conditions are met:

A. The need for absence must be for the purposes of treatment in a licensed or certified program or facility for the purposes of behavior stabilization, physical or mental health treatment.

B. The loss of home or loss of the primary non-paid caregiver.

C. The request must be in writing with supporting evidence included.

D. The request must be prior approved by DDS.

E. A minimum of one visit or one contact each month is required.

NOTE: The DDS Specialist is responsible for conducting or assuring the conducting of the contacts or monitoring visits with applicable documentation filed in the case record.

F. All requests for abeyance are to be faxed to the DDS Waiver Program Director for Adult and Waiver Services. Monthly status reports are required to be submitted to the DDS Waiver Program Director as long as the person is in abeyance. Each request for continuance must be submitted in writing and supported by evidence of treatment status or progress. Requests for continuance must be made prior to the expiration of the abeyance period.

In order for beneficiaries to continue to be eligible for waiver services while they are in abeyance, the following two requirements must be met:

A. It must be demonstrated that a beneficiary needs at least one waiver service as documented in their person centered service plan.

B. Beneficiaries must receive at least one waiver service per month or monthly monitoring.

As stated in the Medical Services Manual, Section 1348, an individual living in a public institution is not eligible for Medicaid.

A. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers and other correctional or holding facilities.

B. Wilderness camps and boot camps are considered a public institution if a governmental unit has any degree of administrative control.

C. Inmate status will continue until the indictment against the individual is dismissed or until he or she is released from custody either as “not guilty” or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.).

Thus, a person who is living in a public institution as defined above would be closed under Medicaid and also under the waiver program.

213.100 Supportive Living Arrangements (Provider owned group homes or apartments) 4-1-12

Persons residing in supportive living arrangements are eligible for the same services and service level as any other waiver participant. Staff working in such arrangements must have hours of compensation prorated according to the number of individuals, waiver and non-waiver, residing in the supportive living arrangement. Additional one-on-one staffing may be provided when the need is justified. Supportive living arrangements include:

A. Existing group homes serving groups of no more than 14 unrelated individuals (age 18 and older) with developmental disabilities in the residential setting.

B. Existing DDS licensed supportive living apartments serving up to 4 unrelated individuals (age 18 and older) with developmental disabilities in each self-contained apartment unit up to the total number of licensed units in the complex.

C. Adults served in their family home, in their own home or in an integrated apartment complex or in an alternative living setting with no more than 4 unrelated individuals with developmental disabilities in the home.

D. Children served in their family home or in an alternative family home with no more than 4 unrelated children who are individuals with developmental disabilities in the home.

Exception: Only those supportive living apartments and group homes licensed by the DDS prior to July 1, 1995 are approved to serve more than 4 adults. No expansions will be approved beyond the July 1, 1995 total capacity (waiver and non-waiver).

214.000 Respite Services 4-1-12

Respite services are provided on a short-term basis to beneficiaries unable to care for themselves due to the absence of or need for relief of non-paid primary caregivers. Room and board may not be claimed when respite is provided in the beneficiary's home or a private place of residence. Room and board is not a covered service except when provided as part of respite furnished in a facility that is approved by the State as a respite care facility.

Receipt of respite services does not necessarily preclude a beneficiary from receiving other services on the same day. For example, a beneficiary may receive day services, such as supported employment, on the same day as respite services.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite may not be furnished for the purpose of compensating relief or substitute staff for supportive living services. Respite services are not to supplant the responsibility of the parent or guardian.

Respite services may be provided through a combination of basic child care and support services required to meet the needs of a child. When respite is provided in a licensed day care facility, licensed day care home or other lawful child care setting, waiver will only pay for the support staff required by the beneficiary's developmental disability. Parents and guardians will remain responsible for the cost of basic child care fees.

Respite services are separate and distinct from educational services provided at a school where attendance is mandated and the primary focus of the institution is the accomplishment of specified educational goals.

Respite may be provided in the following locations:

A. Beneficiary's home or private place of residence.

B. The private residence of a respite care provider.

C. Foster home.

D. Medicaid-certified ICF/MR.

E. Group home.

F. Licensed respite facility.

G. Other community residential facility approved by the state, not a private residence.

H. Licensed or accredited residential mental health facility.

I. Licensed day care facility, licensed day care home or other lawful child care setting. Waiver will only pay for support staff required due to the individual's developmental disability. Waiver will not pay for day care fees.

230.300 Comprehensive Diagnosis and Evaluation 4-1-12

A comprehensive diagnosis and evaluation (D&E) must be administered in order to determine that applicants are individuals with a developmental disability prior to receiving ACS Waiver services from the DDS.

The comprehensive diagnosis and evaluation includes a series of examinations and observations performed or validated and approved by professionals leading to conclusions and findings.

The examinations and/or assessments include, but are not limited to:

A. A thorough medical examination and other evaluations deemed necessary by the physician

B. A psychological assessment

C. A social history/sociological examination

D. An educational assessment, if applicable

E. An appraisal of adaptive behavior

F. All other examinations, assessments and evaluations necessary to describe the beneficiary's needs

G. Areas of Need form

Failure to submit the reassessments in advance of the eligibility expiration date will result in the denial of case management reimbursement for the period the determination is overdue. Failure to obtain any required eligibility determination, whether initial or subsequent time-bound reassessments, may result in the beneficiary's case being closed.

When a beneficiary's case has been closed, the affected person must make a new request for services through the waiver program intake process in order for services to continue. This will be considered a new application to the waiver program.

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P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
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TO: **Arkansas Medicaid Health Care Providers – Developmental Day Treatment Clinic Services**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal DDTCS-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.131	10-13-03	214.131	4-1-12
214.132	10-13-03	214.132	4-1-12
214.133	10-13-03	214.133	4-1-12

Explanation of Updates

Sections 214.131, 214.132 and 214.133 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

214.131 Early Intervention 4-1-12

Early intervention is a facility-based program designed to provide one-on-one direct training to the child *and* the parent or caregiver. The intent of early intervention is to work with parents and caregivers to assist them with training the child. The parent or caregiver of the child must participate in the programming to learn how to work with the child in the home.

A. To be eligible for early intervention services, the child must be an individual with developmental disabilities or developmentally delayed and must not be school age. School age is defined as having reached the age of five years on or before the date set by the Arkansas Department of Education. A child reaching age five after that date is not considered school age until the next school year.

B. Early intervention services must include training the parent or caregiver in meeting the needs of the child and in meeting the goals of the care plan.

C. Coverage is limited to one encounter per day. An early intervention encounter includes the time spent on preparation and service documentation as well as the direct training. Each early intervention encounter must be two hours or more in duration. At each encounter, a minimum of one hour of direct training with the child and the parent or caregiver is required.

214.132 Pre-School 4-1-12

Pre-school service is a facility-based program designed to provide specialized services to children who have been diagnosed as an individual with developmental disabilities or developmentally delayed and who are not school age. School age is defined as having reached the age of five years on or before the date set by the Arkansas Department of Education. A child reaching age five after that date is not considered school age until the next school year.

Services must be provided for the purpose of teaching habilitation goals as set forth in the plan of care. Services are established on a unit-of-service basis. Each unit of service equals one hour. A maximum of five units per day is allowed.

Time spent in transit from the person's place of residence to the provider facility and from the facility back to the person's place of residence is not included in the unit of service calculation.

214.133 Adult Development 4-1-12

Adult development is a facility-based program providing specialized habilitation services to adults who have been diagnosed as an individual with developmental disabilities. Qualifying individuals must be between ages 18 and 21 with a diploma or certificate of completion, or age 21 and older.

A. Adult development services may include prevocational services that prepare a person for employment. Prevocational services:

1. May *not* be job-task oriented, but
2. May include such *habilitation* goals as compliance, attending, task completion, problem solving and safety, and
3. May be provided only to persons who are not expected to be able to join the general work force or to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

B. Prevocational services may not be primarily directed at teaching specific job skills. All prevocational services must be listed in the plan of care as habilitation and may not

address explicit employment objectives. The person's compensation must be less than 50% of minimum wage in order for the training to qualify as prevocational services. Commensurate wage must be paid under a current Wage and Hour Sheltered Workshop Certificate.

C. Documentation must be maintained in each person's file showing that the services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act of 1997.

Adult development services are established on a unit-of-service basis. Each unit of service equals one hour in the facility with a maximum of five units reimbursable per day.

Time spent in transit from the person's place of residence to the provider facility and from the facility back to the person's place of residence is not included in the unit of service calculation.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Federally Qualified Health Center**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal FQHC-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
216.410	10-13-03	216.410	4-1-12

Explanation of Updates

Section 216.410 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Andy Allison, Director

TOC not required

216.410 Informed Consent to Sterilization 4-1-12

A. By signing the Sterilization Consent Form DMS-615, the patient certifies that she or he understands the entire process.

1. By signing the consent form, the person obtaining consent and the physician certify that, to the best of their knowledge, the patient is mentally competent to give informed consent.
2. If any questions concerning this requirement exist, you should contact the Arkansas Medicaid Program for clarification before the sterilization procedure is performed.

B. The person obtaining the consent for sterilization must sign and date the form after the recipient and interpreter sign, if an interpreter is used.

1. This may be done immediately after the recipient and interpreter sign or it may be done later, but it must always be done before the sterilization procedure.
2. The signature will attest to the fact that all elements of informed consent were given and understood and that consent was voluntarily given.

C. By signing the physician's statement on the consent form, the physician is certifying that shortly before the sterilization was performed, he or she again counseled the patient regarding the sterilization procedure.

1. The State defines "shortly before" as one week (seven days) or less before the performance of the sterilization procedure.
2. The physician's signature on the consent form must be an original signature and not a rubber stamp.

D. Informed consent may not be obtained while the person to be sterilized is:

1. In labor or childbirth,
2. Seeking to obtain or obtaining an abortion or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

E. The sterilization must be performed at least 30 days, but not more than 180 days, after the date of informed consent. The following are exceptions to the 30-day waiting period:

1. In the case of premature delivery, provided at least 72 hours have passed between giving the informed consent and performance of the sterilization procedure and counseling and informed consent were given at least 30 days before the expected date of delivery.
2. In the case of emergency abdominal surgery, provided at least 72 hours have passed between giving informed consent and the performance of the sterilization procedure.

Either of these exceptions to the 30-day waiting period must be properly documented on the form DMS-615. **View or print Sterilization Consent Form DMS-615 and checklist**.

F. The person is informed, before any sterilization discussion or counseling, that no benefits or rights will be lost because of refusal to be sterilized and that sterilization is an entirely voluntary matter. This should be explained again just before the sterilization procedure takes place.

G. If the person is an individual with a disability and signs the consent form with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed

with an "X," such as stroke, paralysis, legally blind, etc. If a consent form is received that does not have the statement attached, the claim will be denied.

H. A copy of the properly completed form DMS-615, with all items legible, must be attached to each claim submitted from each provider. Providers include FQHCs, hospitals, physicians, anesthesiologists and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed "Sterilization Consent Form" DMS-615 to the hospital, anesthesiologist and assistant surgeon.

I. Sterilizations are covered only when informed consent is properly documented by means of the form DMS-615.

1. **View or print a checklist for Form DMS-615**, which lists consent form items that DMS medical staff reviews to determine whether a sterilization procedure will be covered.
2. Using the checklist will help ensure the submittal of a correct form DMS-615.

J. The individual undergoing the procedure must receive, from the physician performing the procedure or the facility in which the sterilization procedure takes place, an identical copy of the completed consent form that he or she signed and dated.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
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TO: **Arkansas Medicaid Health Care Providers – Hospital/CAH/End-Stage Renal Disease**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal HOSPITAL-4-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.100	10-13-03	212.100	4-1-12
216.410	10-13-03	216.410	4-1-12

Explanation of Updates

Sections 212.100 and 216.410 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

Toc not required

212.100 Scope – Inpatient 4-1-12

"Inpatient hospital services" are defined in the Arkansas Medical Assistance Program as those items and services ordinarily furnished by the hospital for care and treatment of inpatients and are provided under the direction of a licensed practitioner (physician or dentist with staff affiliation) of a facility maintained primarily for treatment and care of injured persons, individuals with disabilities, or sick persons. Such inpatient services must be medically justified, documented, certified and re-certified by the Quality Improvement Organization (QIO) and are payable by Medicaid if provided on a Medicaid covered day.

A "Medicaid covered day" is defined as a day for which the recipient is Medicaid eligible, the patient's inpatient benefit has not been exhausted, the patient's inpatient stay is medically necessary, the day is not part of a hospital stay for a non-payable procedure or non-authorized procedure (see Sections 220.000 and 244.000), and the claim is filed on time. (See Section III of this manual for reference to "Timely Filing.")

The following services are covered inpatient hospital services if medically necessary for treatment of the patient and if the date of service is a Medicaid covered day:

A. **Accommodation**
"Accommodation" means the type of room provided for the patient while receiving inpatient hospital services. The Medicaid Program will cover the semi-private room or ward accommodations and intensive care. A private room will only be covered when such accommodations are medically necessary, as certified by the patient's attending physician. Private rooms are considered medically necessary only when the patient's condition requires him or her to be isolated to protect his or her health or welfare, or to protect the health of others.

B. **Operating Room**
Operating room charges for services and supplies associated with surgical procedures are covered inpatient hospital services.

C. **Anesthesia**
Anesthesia charges for services and/or supplies furnished by the hospital are covered inpatient hospital services.

D. **Blood Administration**
Blood, blood components and blood administration charges are covered when not available to the recipient from other sources. Hospitals are encouraged to replace blood that is used by a Medicaid recipient through his or her friends and relatives, or through the Red Cross whenever possible.

E. **Pharmacy**
Drugs and biologicals furnished by the hospital for the care and treatment of patients are covered inpatient hospital services. Take-home drugs are non-covered inpatient hospital services under the Arkansas Medicaid Program.

F. **Radiology and Laboratory**
The coverage of inpatient hospital services includes the non-physician services related to machine tests, laboratory and radiology procedures provided to inpatients. The hospital where the patient is hospitalized will be responsible for providing or securing these services. The party who furnishes these non-physician services is permitted to bill only the hospital.

If a patient is transferred to another hospital to receive services on an outpatient basis, the cost of the transfer is included in the hospital reimbursement amount. The ambulance company may not bill Medicaid or the recipient for the service.

G. **Medical, Surgical and Central Supplies**
Necessary medical and surgical supplies and equipment that are furnished by the hospital for the care and treatment of patients are covered inpatient hospital services. Supplies and equipment for use outside the hospital are not covered by Medicaid.

H. **Physical and Inhalation Therapy**
Physical and inhalation therapy and other necessary services, as well as supply charges for these services that are furnished by the hospital, are covered inpatient hospital services.

I. **Delivery Room**
Delivery room charges for services and supplies associated with obstetrical procedures are covered inpatient hospital services.

J. **Other**
Services other than the non-covered services identified in Section 212.200, which are not specified above.

216.410 Informed Consent to Sterilization 4-1-12

A. By signing the Sterilization Consent Form DMS-615, the patient certifies that she or he understands the entire process.

1. By signing the consent form, the person obtaining consent and the physician certify that, to the best of their knowledge, the patient is mentally competent to give informed consent.
2. If any questions concerning this requirement exist, you should contact the Arkansas Medicaid Program for clarification before the sterilization procedure is performed.

B. The person obtaining the consent for sterilization must sign and date the form after the recipient and interpreter sign, if an interpreter is used.

1. This may be done immediately after the recipient and interpreter sign or it may be done later, but it must always be done before the sterilization procedure.
2. The signature will attest to the fact that all elements of informed consent were given and understood and that consent was voluntarily given.

C. By signing the physician's statement on the consent form, the physician is certifying that shortly before the sterilization was performed, he or she again counseled the patient regarding the sterilization procedure.

1. The State defines "shortly before" as one week (seven days) or less before the performance of the sterilization procedure.
2. The physician's signature on the consent form must be an original signature and not a rubber stamp.

D. Informed consent may not be obtained while the person to be sterilized is:

1. In labor or childbirth,
2. Seeking to obtain or obtaining an abortion or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

E. The sterilization must be performed at least 30 days, but not more than 180 days, after the date of informed consent. The following exceptions to the 30-day waiting period must be

properly documented on the form DMS-615. **View or print Sterilization Consent Form DMS-615 and Checklist.**

1. In the case of premature delivery, provided that at least 72 hours have passed between giving the informed consent and performance of the sterilization procedure and that counseling and informed consent were given at least 30 days before the expected date of delivery.
2. In the case of emergency abdominal surgery, provided that at least 72 hours have passed between giving informed consent and the performance of the sterilization procedure.

F. The person is informed, before any sterilization discussion or counseling, that no benefits or rights will be lost because of refusal to be sterilized and that sterilization is an entirely voluntary matter. This should be explained again just before the sterilization procedure takes place.

G. If the person is an individual with a disability and signs the consent form with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed with an "X," such as stroke, paralysis, legally blind, etc. If a consent form is received that does not have the statement attached, the claim will be denied.

H. A copy of the properly completed form DMS-615, with all items legible, must be attached to each claim submitted from each provider. Providers include hospitals, physicians, anesthesiologists and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed Sterilization Consent Form DMS-615 to the hospital, anesthesiologist and assistant surgeon.

I. Sterilizations are covered only when informed consent is properly documented by means of the form DMS-615.

1. **View or print a Checklist for Form DMS-615,** which lists consent form items that DMS medical staff reviews to determine whether a sterilization procedure will be covered.
2. Using the checklist will help ensure the submittal of a correct form DMS-615.

J. The individual undergoing the procedure must receive, from the physician performing the procedure or the facility in which the sterilization procedure takes place, an identical copy of the completed consent form that he or she signed and dated.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
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TO: **Arkansas Medicaid Health Care Providers – IndependentChoices**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal INCHOICE-2-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
200.100	11-1-09	200.100	4-1-12

Explanation of Updates

Section 200.100 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

200.100 IndependentChoices 4-1-12

The Arkansas Department of Human Services (DHS) was granted an 1115 Research and Demonstration waiver to implement IndependentChoices, a Cash and Counseling Demonstration and Evaluation Project in 1998. On April 1, 2008, the IndependentChoices program became a state plan service under 1915(j) of the Social Security Act. IndependentChoices is operated by the Division of Aging and Adult Services (DAAS). The program offers Medicaid-eligible aged and individuals with disabilities an opportunity to self-direct their personal assistant services.

The IndependentChoices program has been operational since 1998. Some of the results of evaluations performed by Mathematica Policy Research, Inc. specifically identified these results that may positively impact community services in Arkansas:

A. IndependentChoices decreased unmet needs.

B. IndependentChoices improved lives.

C. IndependentChoices participants were less likely to have contractures or urinary tract infections develop or worsen.

D. Nursing home costs decreased by 18% over a three year period for IndependentChoices participants.

Operation of the IndependentChoices program as a state plan service will use the positive foundation established through lessons learned as an 1115 Research and Demonstration Waiver to continue to offer opportunities for improved life in the community.

IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid beneficiaries receiving or needing personal assistant services. Personal Assistant services in IndependentChoices include state plan personal care for Medicaid beneficiaries and Adult Companion and Homemaker services for ElderChoices beneficiaries. IndependentChoices offers an allowance and counseling services in place of traditional agency-provided personal assistance services and items related to personal assistance needs.

The participant or designee is the employer and accepts the responsibility in directing the work of their employee to the degree necessary to meet their individual needs for assistance with activities of daily living and instrumental activities of daily living.

If the IC participant can make decisions regarding his or her care but does not feel comfortable reading and filling out forms or talking on the phone, he or she can appoint a Communications Manager. The Communications Manger can act as the participant's voice and complete and sign forms, etc., but will not make decisions for the participant. The Communications Manager will not hire, train, supervise or fire the personal assistant for the IC participant.

If the participant needs someone to hire and supervise the personal assistant, make decisions about care and administer the cash expenditure plan as well as complete all forms, a Decision-Making Partner will be appointed.

IndependentChoices participants or their Decision-Making Partners must be able to assume the responsibilities of becoming an employer by hiring, training, supervising and firing if necessary their directly hired workers. In doing so the program participant accepts the risks, rights and responsibilities of directing their care and having their health care needs met.

The IndependentChoices program respects the employer authority of the Medicaid beneficiary who chooses to direct his or her care by hiring an employee who will be trained by the employer or Decision-Making Partner to provide assistance how, when, and where the employer or Decision-Making Partner determines will best meet the participant's individual needs. The Medicaid beneficiary assumes the risks, rights and responsibilities of having their health care needs met in doing so.

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Division of Medical Services
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TO: **Arkansas Medicaid Health Care Providers – Inpatient Psychiatric Services for Under Age 21**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal INPPSYCH-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
215.220	10-13-03	215.220	4-1-12

Explanation of Updates

Section 215.220 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Andy Allison, Director

TOC not required

215.220 Composition of the Facility-Based Team (42 CFR 441.156) 4-1-12

A. The team must include at least one of the following:

1. A board eligible or board certified psychiatrist;
2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy or
3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Board of Examiners in Psychology.

B. The team must also include at least one of the following:

1. Psychiatric social worker;
2. A registered nurse with specialized training or one year's experience in treating individuals with mental illness;
3. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating individuals with mental illness or
4. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State Psychological Association.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Living Choices Assisted Living**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal LCAL-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
210.000	10-13-03	210.000	4-1-12
211.100	6-1-09	211.100	4-1-12

Explanation of Updates

Sections 210.000 and 211.100 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Andy Allison, Director

TOC not required

210.000 PROGRAM COVERAGE 4-1-12

Living Choices Assisted Living is a home and community-based services waiver program that is administered jointly by the Division of Medical Services (DMS, the state Medicaid agency) and the Division of Aging and Adult Services (DAAS), under the waiver authority of Section 1915(c) of the Social Security Act. Home and community-based services waiver programs cover services designed to allow specific populations of individuals (in this case, persons aged 21 and older who are blind, elderly or an individual with disabilities and eligible for a nursing home intermediate level of care) to live in their own homes or in certain types of congregate settings.

The rules and regulations for licensure of Level II Assisted Living Facilities (ALF) are administered by the Office of Long Term Care within DMS. As agencies of the Arkansas Department of Human Services (DHS), DAAS, DMS and the Division of County Operations (DCO) administer the policies and procedures and the rules and regulations governing provider and beneficiary participation in the Living Choices Program.

Individuals found eligible for the Living Choices Program may participate in the program *only* as residents of licensed Level II ALF.

211.100 Eligibility for the Living Choices Assisted Living Program 4-1-12

A. Individuals may participate in the Living Choices Assisted Living Program only as residents of licensed Level II Assisted Living Facilities (ALF). To qualify for the Living Choices Program, an individual must be aged 65 or older, or age 21 or older and blind or an individual with physical disabilities as determined by the Social Security Administration (SSA) or the Department of Human Services (DHS) Medical Review Team, and must be found to require a nursing facility intermediate level of care. Individuals requiring skilled nursing care are not eligible for the Living Choices Assisted Living Program.

B. Candidates for participation in the program (or their representatives) must make an application at the DHS office in the county in which the Level II ALF is located. Eligibility is based on non-medical and medical criteria. Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a "functional disability."

C. To be determined if the individual has a functional disability, an individual must meet at least one of the following three criteria, as determined by a licensed medical professional.

1. The individual is unable to perform either of the following:
   a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon, another person; or
   b. At least 2 of the 3 ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or
2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired, requiring substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or others; or
3. The individual has a diagnosed medical condition that requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening.

D. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition that is temporary and expected to last no more than 21 days. However, that individual shall not receive waiver services or

benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than 21 days.

E. Individuals with serious mental illness, except as specified in part C above, or individuals with intellectual disabilities are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual disability and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual disability must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.

F. Registered Nurses (RNs) employed by the Division of Aging and Adult Services (DAAS) perform a comprehensive assessment of each applicant to determine his or her personal assistance and health care needs. The assessment tool is the Assisted Living Comprehensive Assessment (**View or print form AAS-9565**), which establishes the candidate's "tier of need." There are four tiers of need in the Living Choices Program, each tier progressively requiring more bundled services.

G. DAAS nurses perform periodic reevaluations (at least annually) of the need for a nursing home intermediate level of care. Reevaluations must be performed more often if needed to ensure that a resident is appropriately placed in the Living Choices Assisted Living Program and is receiving services suitable to his or her needs.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Medicare/Medicaid Crossover Only**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal MEDX-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.000	10-15-09	214.000	4-1-12

Explanation of Updates

Section 214.000 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Andy Allison, Director

TOC not required

214.000 Eligibility Criteria for QMB Program 4-1-12

This program has been designed to assist low income elderly and individuals with disabilities who are covered by Medicare Part A. The person must be 65 or older, blind or an individual with a disability and eligible for or enrolled in Medicare Part A. Arkansas Medicaid also covers Part B medical services coinsurance and deductible amounts for beneficiaries enrolled under the above criteria.

Beneficiaries interested in applying for the QMB Program should contact their local county Department of Human Services office. The applicant should call the county office to inquire about the eligibility criteria, what documents are needed to determine eligibility and whether an appointment is necessary.

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Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Personal Care**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal PERSCARE-3-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
213.540	10-1-07	213.540	4-1-12
217.120	10-13-03	217.120	4-1-12
244.000	10-1-08	244.000	4-1-12

Explanation of Updates

Sections 213.540, 217.120 and 244.000 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Andy Allison, Director

TOC not required

213.540 Employment-related Personal Care Outside the Home 4-1-12

No condition of this section alters or adversely affects the status of individuals who are furnished personal care in sheltered workshops or similarly authorized habilitative environments. There may be a few beneficiaries working in sheltered workshops solely or primarily because they have access to personal care in that setting. This expansion of personal care outside the home may enable some of those individuals to move or attempt to move into an integrated work setting.

A. Personal care may be provided outside the home when the requirements in subparts A1 through A5 are met and the services are necessary to assist an individual with a disability to obtain or retain employment.

1. The beneficiary must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.
2. The beneficiary must be aged 16 or older.
3. The beneficiary's disability must meet the Social Security/SSI disability definition.
   a A beneficiary's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.
   b. If uncertain whether a beneficiary qualifies under this disability provision, contact the Department of Human Services local office in the county in which the beneficiary resides.
4. One of the following two conditions must be met.
   a. The beneficiary must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability).
   b. Alternatively, the beneficiary must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.
5. The beneficiary must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.

B. Personal care aides may assist beneficiaries with personal care needs in a beneficiary's workplace and at employment-related locations, such as human resource offices, employment agencies or job interview sites.

C. Employment-related personal care associated with transportation is covered as follows.

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking.
2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see Section 215.300, part F) in the service plan and all pertinent service documentation.
3. Medicaid does not cover mileage associated with any personal care service.
4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is neither subject to nor included in the eight-hour per month benefit limit that applies to shopping for personal care items and transportation to stores to shop for personal care items, but it is included in the 64-hour per month personal care benefit limit for beneficiaries aged 21 and older.

D. All personal care for beneficiaries under age 21 requires prior authorization.

E. Providers furnishing both employment-related personal care outside the home and non-employment related personal care at home or elsewhere for the same beneficiary must comply with the applicable rules at Sections 215.350, 215.351 and 262.100.

217.120 Duration of Benefit Extension 4-1-12

A. Benefit extensions are granted for six months or the life of the service plan, whichever is shorter.

B. When the beneficiary's diagnosis indicates a permanent disability, DMS may assign a Benefit Extension Control Number effective for one year. For individuals who are beneficiaries with permanent disabilities, benefit extension requests will be necessary only once every 12 months unless the service plan changes.

1. If there is a service plan revision, the provider must submit a benefit extension request for the number of hours in the revised service plan.
2. Upon approval of the requested extension, the updated benefit extension approval file is valid for 12 months from the beginning of the month in which the revised service plan takes effect.
3. If there is a service plan revision before 12 months have passed, the provider must initiate the benefit extension approval process again.

244.000 Duration of PA 4-1-12

A. Personal Care PAs are generally assigned for six months or for the life of the service plan, whichever is shorter.

B. The contracted QIO may validate a PA for one year if the provider requests an extended PA because the beneficiary is an individual with a permanent disability.

1. A one-year PA remains valid only if the service plan and services remain unchanged and the provider meets all Personal Care Program requirements.
2. Providers receiving extended PAs for individuals who are beneficiaries with a permanent disability must continue to follow Personal Care Program policy regarding regular assessments and service plan renewals and revisions.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Physician/Independent Lab/CRNA/Radiation Therapy Center**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal PHYSICN-3-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
203.240	10-13-03	203.240	4-1-12
251.280	11-1-08	251.280	4-1-12

Explanation of Updates

Sections 203.240 and 251.280 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Andy Allison, Director

TOC not required

203.240 Physician's Role in the Portable X-Ray Services Program 4-1-12

Medicaid covers portable X-ray services when provided to eligible Medicaid recipients by qualified providers. Portable X-ray services may be covered upon the written order of the recipient's physician at the recipient's place of residence. "Place of residence" in the Portable X-Ray Services Program is defined by the Medicaid Program as the recipient's own dwelling, an apartment or relative's home, a boarding home, a residential care facility, a skilled nursing facility, or an intermediate care facility for individuals with intellectual disabilities. Portable X-Ray Services are not covered in a hospital.

251.280 Hysterectomies 4-1-12

Hysterectomies, except those performed for malignant neoplasm, carcinoma in-situ and severe dysplasia will require prior authorization regardless of the age of the beneficiary. (See Section 261.100 of this manual for instructions for obtaining prior authorization.) Those hysterectomies performed for carcinoma in-situ or severe dysplasia must be confirmed by a tissue report. The tissue report must be obtained prior to surgery. Cytology reports alone will not confirm the above two diagnoses, nor will cytology reports be considered sufficient documentation for performing a hysterectomy. Mild or moderate dysplasia is not included in the above and any hysterectomy performed for mild or moderate dysplasia will require prior authorization.

A. Any Medicaid beneficiary who is to receive a hysterectomy, regardless of her age, must be informed both orally and in writing that the hysterectomy will render her permanently incapable of reproduction. The patient or her representative may receive this information from the individual who secures the usual authorization for the hysterectomy procedure.

   The patient or her representative, if any, must sign and date the Acknowledgement of Hysterectomy Information (Form DMS-2606) not more than 180 days prior to the hysterectomy procedure being performed. **View or print form DMS-2606 and instructions for completion.** Copies of this form can be ordered from HP Enterprise Services according to the procedures in Section III.

   If an individual with disabilities signs the consent form with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed with an "X," such as stroke, paralysis, legally blind, etc

   Please note that the acknowledgement statement must be submitted with the claim for payment. The Medicaid agency will not approve any hysterectomy for payment until the acknowledgement statement has been received.

   If the patient needs the Acknowledgement of Hysterectomy Information Form (DMS-2606) in an alternative format, such as large print, contact our Americans with Disabilities Coordinator. **View or print the Americans with Disabilities Coordinator contact information.**

   For hysterectomies for the mentally incompetent, the acknowledgement of sterility statement is required. A guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition and the acknowledgement statement must be attached to the claim.

B. Random Audits of Hysterectomies

   All hysterectomies paid by Federal and State funds will be subject to random selection for post-payment review. At the time of such review, the medical records must document the medical necessity of hysterectomies performed for carcinoma in-situ and severe dysplasia

and must contain tissue reports confirming the diagnosis. The tissue must have been obtained prior to surgery.

The medical record of those hysterectomies performed for malignant neoplasms must contain a tissue report confirming such a diagnosis. However, the tissue may be obtained during surgery, e.g., frozen sections. Any medical record found on post-payment review which does not contain a tissue report confirming the diagnosis or any medical record found which does not document the medical necessity of performing such surgery will result in recovery of payments made for that surgery.

C. Hysterectomies Performed for Sterilization

Medicaid **does not cover** any hysterectomy performed for the sole purpose of sterilization.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Portable X-Ray Services**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal PORTX-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
213.000	11-1-06	213.000	4-1-12

Explanation of Updates

Section 213.000 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

213.000 Scope 4-1-12

Portable X-ray services may be covered for a Medicaid beneficiary upon the written order of the beneficiary's primary care physician (PCP). The claim for reimbursement must indicate the name of the physician who ordered the service before payment may be made.

Portable X-ray services may be provided to a beneficiary in his or her place of residence. In the Portable X-ray Program, the place of residence is defined by the Medicaid Program as the beneficiary's own dwelling, an apartment or relative's home, a boarding home, a residential care facility, a nursing facility or an intermediate care facility for individuals with intellectual disabilities. Portable X-ray services are not covered in a hospital.

Portable X-ray services are limited to the following:

A. Skeletal films involving arms and legs, pelvis, vertebral column and skull;

B. Chest films that do not involve the use of contrast media and

C. Abdominal films that do not involve the use of contrast media.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Rural Health Clinic**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal RURLHLTH-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
217.231	10-13-03	217.231	4-1-12

Explanation of Updates

Section 217.231 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

217.231 Informed Consent to Sterilization 4-1-12

A. By signing the Sterilization Consent Form DMS-615, the patient certifies that she or he understands the entire process.

1. By signing the consent form, the person obtaining consent and the physician certify that, to the best of their knowledge, the patient is mentally competent to give informed consent.
2. If any questions concerning this requirement arise, you should contact the Arkansas Medicaid Program for clarification ***before*** the sterilization procedure is performed.

B. The person obtaining the consent for sterilization must sign and date the form ***after*** the recipient and interpreter sign, if an interpreter is used.

1. This may be done immediately after the recipient and interpreter sign, or it may be done later, but it must always be done ***before*** the sterilization procedure.
2. The signature will attest to the fact that all elements of informed consent were given and understood and that consent was voluntarily given.

C. By signing the physician's statement on the consent form, the physician is certifying that shortly before the sterilization was performed, he or she again counseled the patient regarding the sterilization procedure.

1. The State defines "shortly before" as one week (seven days) or less before the performance of the sterilization procedure.
2. The physician's signature on the consent form must be an ***original*** signature and not a rubber stamp.

D. Informed consent may not be obtained while the person to be sterilized is:

1. In labor or childbirth,
2. Seeking to obtain or obtaining an abortion, or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

E. The sterilization must be performed at least 30 days, but not more than 180 days, after the date of informed consent. The following exceptions to the 30-day waiting period must be properly documented on the form DMS-615. **View or print Sterilization Consent Form DMS-615 and checklist.**

1. In the case of premature delivery, provided at least 72 hours have passed between giving the informed consent and performance of the sterilization procedure, and counseling and informed consent were given at least 30 days before the expected date of delivery.
2. In the case of emergency abdominal surgery, provided at least 72 hours have passed between giving informed consent and the performance of the sterilization procedure.

F. The person is informed, before any sterilization discussion or counseling, that no benefits or rights will be lost because of refusal to be sterilized and that sterilization is an entirely voluntary matter. This should be explained again just before the sterilization procedure takes place.

G. If the person is an individual with disabilities and signs the consent form with an "X," two witnesses must also sign and include a statement regarding the reason the patient signed

with an "X," such as stroke, paralysis, legally blind, etc. If a consent form is received that does not have the statement attached, the claim will be denied.

H. A copy of the properly completed form DMS-615, with all items legible, must be attached to each claim submitted from each provider. Providers include RHCs, FQHCs, hospitals, physicians, anesthesiologists and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed Sterilization Consent Form DMS-615 to the hospital, anesthesiologist and assistant surgeon.

I. Sterilizations are covered only when informed consent is properly documented by means of the form DMS-615.

1. The checklist for form DMS-615 lists consent form items that DMS medical staff reviews to determine whether a sterilization procedure will be covered. **View or print Sterilization Consent Form DMS-615 and checklist.**
2. Using the checklist will help ensure the submittal of a correct form DMS-615.

J. The individual undergoing the procedure must receive, from the physician performing the procedure or the facility in which the sterilization procedure takes place, an identical copy of the completed consent form that he or she signed and dated.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Transportation**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal TRANSP-3-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
261.000	7-1-11	261.000	4-1-12

Explanation of Updates

Section 261.000 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

261.000 Arkansas Medicaid Participation Requirements for DDTCS Transportation Providers 4-1-12

All non-emergency medical transportation will be provided by the transportation broker for the region in which the beneficiary lives with the exception of transportation to and from a Developmental Day Treatment Clinic Services (DDTCS) center when the transportation is provided by the center.

The DDTCS provider may choose to provide transportation services for individuals with developmental disabilities as a fee-for-service provider to and from a DDTCS facility. A transportation broker must provide transportation to and from medical providers.

The DDTCS transportation providers must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program:

A. The provider must complete a provider application (Form DMS-652), a Medicaid contract (Form DMS-653), an Ownership and Conviction Disclosure (Form DMS-675), a Disclosure of Significant Business Transactions (Form DMS-689) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (Form DMS-652), Medicaid contract (Form DMS-653), Ownership and Conviction Disclosure (Form DMS-675), Disclosure of Significant Business Transactions (Form DMS-689) and Request for Taxpayer Identification Number and Certification (Form W-9).**

B. The provider application and Medicaid contract must be approved by the Arkansas Medicaid Program.

C. The provider must submit:

1. A copy of his or her current vehicle registration for each vehicle to be used for DDTCS transportation
2. A copy of the driver's current commercial and/or non-commercial driver's license(s) appropriate for the operation of any motor vehicle(s) the driver will be operating/driving to transport DDTCS beneficiaries
3. Proof of automobile insurance for each vehicle with minimum liability coverage of $50,000.00 per person per occurrence
4. Consent for Release of Information (Form DMS-619), completed by each driver. **View or print Consent for Release of Information Form DMS-619.**
5. Provider agreement

D. The provider must subsequently submit, upon receipt, proof of the periodic renewal of each of the following:

1. Vehicle registration
2. Commercial and/or non-commercial driver's license(s) appropriate for the operation of any motor vehicle(s) the driver will be operating/driving to transport DDTCS beneficiaries
3. Required liability insurance

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
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TO: **Arkansas Medicaid Health Care Providers – Section I**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecI-4-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
102.000	9-15-09	102.000	4-1-12
105.100	9-15-09	105.100	4-1-12
105.160	10-13-03	105.160	4-1-12
122.200	10-13-03	122.200	4-1-12
124.150	9-15-09	124.150	4-1-12
124.160	6-1-08	124.160	4-1-12
124.170	6-1-08	124.170	4-1-12
124.230	9-15-09	124.230	4-1-12

Explanation of Updates

Sections 102.000, 105.100, 105.160, 122.200, 124.150, 124.160, 124.170, and 124.230 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

TOC not required

102.000 Legal Basis of the Medicaid Program 4-1-12

Title XIX of the Social Security Act created a joint federal-state medical assistance program commonly referred to as Medicaid. Ark Code Ann § 20-77-107 authorizes the Department of Human Services to establish a Medicaid Program in Arkansas. The Medicaid Program provides necessary medical services to eligible persons who would not be able to pay for such services.

Title XIX of the Social Security Act provides for federal grants to states for medical assistance programs. The stated purpose of Title XIX is to enable the states to furnish the following assistance:

A. Medical assistance to families with dependent children, the aged, the blind, individuals with permanent and total disabilities, the medically needy and children under 18 whose income and resources are insufficient to meet the costs of necessary medical services

B. Rehabilitation and other services to help these families and individuals attain or retain the capability for independence or self-care

In Arkansas, the Division of Medical Services (DMS) administers the Medicaid Program. Within the Division, the Office of Long Term Care (OLTC) is responsible for nursing home policy and procedures.

105.100 Alternatives for Adults with Physical Disabilities 4-1-12

The Alternatives for Adults with Physical Disabilities (APD) waiver program is for individuals with a disability age 21 through 64 who receive Supplemental Security Income (SSI) or who are Medicaid eligible by virtue of their disability and who, but for the services provided by the waiver program, would require a nursing facility level of care.

APD eligibility requires a determination of categorical eligibility, a level of care determination, the development of a plan of care and a cost comparison to determine the cost-effectiveness of the plan of care. The beneficiary must be notified that he/she may choose either home and community-based services or institutional services.

The services offered through the waiver are:

A. Environmental accessibility/adaptations/adaptive equipment

B. Attendant care

These services are available only to individuals who are eligible under the waiver's conditions. Detailed information is found in the APD provider manual.

105.160 Living Choices Assisted Living 4-1-12

Living Choices Assisted Living is a home- and community-based services waiver that is administered jointly by the Division of Aging and Adult Services (DAAS) and the Division of Medical Services (DMS). Qualifying individuals are persons aged 21 and older who are blind, elderly or individuals with disabilities and who have been determined by Medicaid to be eligible for an intermediate level of care in a nursing facility.

Participants in Living Choices must reside in Level II assisted living facilities (ALFs), in apartment-style living units. The assisted living environment encourages and protects individuality, privacy, dignity and independence. Each Living Choices participant receives personal, health and social services in accordance with an individualized plan of care developed and maintained in cooperation with a DAAS-employed registered nurse. A participant's individualized plan of care is designed to promote and nurture his or her optimal health and well being.

Living Choices providers furnish "bundled services" in the amount, frequency and duration required by the Living Choices plans of care. They facilitate participants' access to medically

necessary services that are not components of Living Choices bundled services, but which are ordered by participants' plans of care. Living Choices providers receive per diem Medicaid reimbursement for each day a participant is in residence and receives services. The per diem amount is based on a participant's "tier of need," which DAAS-employed RNs determine and periodically re-determine by means of comprehensive assessments performed in accordance with established medical criteria. There are four tiers of need.

Living Choices participants are eligible to receive up to nine Medicaid-covered prescriptions per month. More detailed information may be found in the Living Choices Assisted Living provider manual.

122.200 District Social Security Offices 4-1-12

Social Security representatives are responsible for evaluating an individual's circumstances to determine eligibility for the Supplemental Security Income (SSI) program administered by the Social Security Administration. SSI includes aged, blind and individuals with disabilities categories. The SSI aid categories are listed in Section 124.000.

To be eligible for SSI, an aged, blind or individual with disabilities must also meet income, resource and other eligibility criteria.

Individuals entitled to SSI automatically receive Medicaid.

124.150 Qualified Medicare Beneficiaries (QMB) 4-1-12

The Qualified Medicare Beneficiary (QMB) group was created by the Medicare Catastrophic Coverage Act and uses Medicaid funds to assist low-income Medicare beneficiaries. QMBs do not receive the full range of Medicaid benefits. For example, QMBs do not receive prescription drug benefits from Medicaid or drugs not covered under Medicare Part D. If a person is eligible for QMB, Medicaid pays the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance, less any Medicaid cost sharing, for Medicare covered medical services. Medicaid also pays the Medicare Part A hospital deductible and the Medicare Part A coinsurance, less any Medicaid cost sharing. Medicaid pays the Medicare Part A premium for QMBs whose employment history is insufficient for Title XVIII to pay it. Certain QMBs may be eligible for other limited Medicaid services. Only individuals considered to be Medicare/Medicaid dually eligible qualify for coverage of Medicaid services that Medicare does not cover.

To be eligible for QMB, individuals must be age 65 or older, blind or an individual with disabilities and enrolled in Medicare Part A or conditionally eligible for Medicare Part A. Their countable income may equal but may not exceed 100% of the Federal Poverty Level (FPL). Countable resources may be equal to but not exceed twice the current Supplemental Security Income (SSI) resource limitations.

Generally, individuals may not be certified in a QMB category and in another Medicaid category simultaneously. However, some QMBs may simultaneously receive assistance in the medically needy categories, SOBRA pregnant women (61 and 62), Family Planning (69) and TB (08). QMB generally do not have Medicaid coverage for any service that is not covered under Medicare; with the exception of the above listed categories and individuals dually eligible.

Individuals eligible for QMB receive a plastic Medicaid ID card. Providers must view the electronic eligibility display to verify the QMB category of service. The category of service for a QMB will reflect QMB-AA, QMB-AB or QMB-AD. The system will display the current eligibility.

Most providers are not federally mandated to accept Medicare assignment (See Section 142.700). However, if a physician (by Medicare's definition) or non-physician provider desires Medicaid reimbursement for coinsurance or deductible on a Medicare claim, he or she must accept Medicare assignment on that claim (see Section 142.200 D) and enter the information required by Medicare on assigned claims. When a provider accepts Medicare according to Section 142.200 D, the beneficiary is not responsible for the difference between the billed charges and the Medicare allowed amount. Medicaid will pay a QMB's or Medicare/Medicaid

dual eligible's Medicare cost sharing (less any applicable Medicaid cost sharing) for Medicare covered services.

Interested individuals may be directed to apply for the QMB program at their local Department of Human Services (DHS) county office.

124.160 Qualifying Individuals-1 (QI-1) 4-1-12

The Balanced Budget Act of 1997, Section 4732, (Public law 105-33) created the Qualifying Individuals-1 (QI-1) aid category. Individuals eligible as QI-1 are not eligible for Medicaid benefits. They are eligible only for the payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. Individuals eligible for QI-1 do not receive a Medicaid card. Additionally, unlike QMBs and SMBs, they may not be certified in another Medicaid category for simultaneous periods. Individuals who meet the eligibly requirements for both QI-1 and medically needy spend down must choose which coverage they want for a particular period of time.

Eligibility for the QI-1 program is similar to that of the QMB program. The individuals must be age 65 or older, blind or an individual with disabilities and entitled to receive Medicare payment Medicare Part A hospital insurance and Medicare Part B medical insurance. Countable income must be at least 120% but less than 135% of the current Federal Poverty Level.

Countable resources may equal but not exceed twice the current SSI resource limitations.

124.170 Specified Low-Income Medicare Beneficiaries (SMB) 4-1-12

The Specified Low-Income Medicare Beneficiaries Program (SMB) was mandated by Section 4501 of the Omnibus Budget Reconciliation Act of 1990.

Individuals eligible as specified low-income Medicare beneficiaries (SMB) are not eligible for the full range of Medicaid benefits. They are eligible only for Medicaid payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered. SMB individuals do not receive a Medicaid card.

Eligibility criteria for the SMB program are similar to those for QMB program. The individuals must be aged 65 or older, blind or an individual with disabilities and entitled to receive Medicare Part A hospital insurance and Medicare Part B insurance. Their countable income must be greater than, but not equal to, 100% of the current Federal Poverty Level and less than, but not equal to, 120% of the current Federal Poverty Level.

The resource limit may be equal to but not exceed twice the current SSI resource limitations.

Interested individuals may apply for SMB eligibility at their local Department of Human Services (DHS) county office.

124.230 Working Disabled 4-1-12

The Working Disabled category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are aged 16 through 64, individuals with disabilities as defined by Supplemental Security Income (SSI) criteria and who meet the income and resource criteria may be eligible in this category.

There are two levels of cost sharing in this aid category, depending on the individual's income:

A. Regular Medicaid cost sharing.

   Beneficiaries with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy, inpatient hospital and prescription services for eyeglasses). They are designated in the system as "WD RegCO."

B. New cost sharing requirements.

Beneficiaries with gross income equal to or greater than 100% FPL have cost sharing for more services and are designated in the system as “WD NewCo”.

The cost sharing amounts for the “WD NewCo” eligibles are listed in the chart below:

Program Services	**New Co-Payment***
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Child Health Management Services	$10 per day
Chiropractor	$10 per visit
Dental	$10 per visit (no co-pay on EPSDT dental screens)
Developmental Disability Treatment Center Services	$10 per day
Diapers, Underpads and Incontinence Supplies	None
Domiciliary Care	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Emergency Department: Emergency Services	$10 per visit
Emergency Department: Non-emergency Services	$10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals aged 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital’s Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None

Program Services	New Co-Payment*
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the facility's Medicaid per diem for the first Medicaid-covered day
Outpatient Behavioral Health	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals aged 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of the first covered day's Medicaid inpatient per diem
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate per unit
Occupational Therapy (Age 21 and older have limited coverage**)	$10 per visit
Physical Therapy (Age 21 and older have limited coverage**)	$10 per visit
Speech Therapy (Age 21 and older have limited coverage**)	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Visual Care	$10 per visit

*** Exception:** Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD beneficiaries (Aid Category 10) who temporarily enter a nursing home and continue to meet WD eligibility criteria will be exempt from the co-payments listed above.

**** Exception:** This service is NOT covered for individuals within the Occupational, Physical and Speech Therapy Program for individuals aged 21 and older.

NOTE: Providers must consult the appropriate provider manual to determine coverage and benefits.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
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TO: **Arkansas Medicaid Health Care Providers – Section V**

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecV-12-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
DMS-615	4-96	DMS-615	4-12
DMS-2606	4-07	DMS-2606	4-12

Explanation of Updates

Forms DMS-615 and DMS-2606 are updated to comply with Act 98 - Respectful Language Regarding Disabilities.

This transmittal and the enclosed forms are for informational purposes only. **Please do not complete the enclosed forms.**

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Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison, Director

DIVISION OF MEDICAL SERVICES
ARKANSAS MEDICAID - TITLE XIX
ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION

ALWAYS COMPLETE THIS SECTION

Beneficiary's Name _____ Medicaid ID # _____

Physician's Name _____ Date of Hysterectomy _____

COMPLETE ONLY ONE OF THE REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION

Section A: Complete this section for beneficiary who acknowledges receipt prior to hysterectomy.
I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

Witness Signature _____ Date _____ Patient's Signature _____ Date _____

Section B: Complete this section when any of the exceptions listed below is applicable.
I certify that before I performed the hysterectomy procedure on the beneficiary listed above: (Check one)

1. [ ] Prior to the hysterectomy being performed, I informed her that this operation would make her permanently incapable of reproducing. (This certification is for retroactively eligible beneficiaries only.)
2. [ ] She was already sterile due to _____ (Cause of Sterility)
3. [ ] She had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe emergency situation:

_____

Physician's Signature _____ Date _____

Section C: Complete this section for mentally-incompetent beneficiary only.
The guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition must be attached to the claim.

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy being performed, that if a hysterectomy is performed on the above beneficiary, it will render her permanently incapable of reproducing.

Witness Signature _____ Date _____ Patient's Representative Signature _____ Date _____

PHYSICIAN'S STATEMENT FOR MENTALLY INCOMPETENT

I affirm that the hysterectomy I performed on the above beneficiary was medically necessary due to

_____
Reason for Hysterectomy

and was not done for sterilization purposes, and that to the best of my knowledge, the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on her, I counseled her representative, orally and in writing, that the hysterectomy would render that individual permanently incapable of reproducing; and, the individual's representative has signed a written acknowledgement of receipt of the foregoing information.

Physician's Signature _____ Date _____

Attach a copy to claim form when submitting for payment. Provide copies for patient and for your files.
ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE.
DMS - 2606 (Rev. 4/12)

Instructions for Completing the Acknowledgement of Hysterectomy Statement Form DMS-2606:

The header information of the Acknowledgement Statement (Form DMS-2606) must be completed on all forms. Only one of the remaining sections should be completed depending on the circumstances.

Section A
Must be completed for the beneficiary who acknowledges receipt of information prior to surgery. For beneficiaries with physical disabilities, the Acknowledgement of Hysterectomy statement (Form DMS-2606) must be signed by the patient. If the patient signs with an "X", two witnesses must also sign and include a statement regarding the reason the patient signed with an "X", such as stroke, paralysis, legally blind, etc. This procedure is to be used for patients who do not have intellectual disabilities.

Section B
Must be completed when any of the exceptions listed below exist:

1. Eligibility is retroactive.
2. She was already sterile and the cause of sterility.
3. The hysterectomy was performed because of a life threatening situation and the information concerning sterility could not be given prior to the hysterectomy. The emergency situation must be described.

Section C
Must be completed for the mentally incompetent beneficiary. The guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition must be attached to the claim.

Providers may order a supply of Form DMS-2606 from the HP Enterprise Services Provider Assistance Center. View or print the HP Enterprise Services Provider Assistance Center address.

Please note that the acknowledgement statement must be submitted with the claim for payment.

The acknowledgement statement must be signed by the patient or her representative. The Medicaid agency will not approve payment for any hysterectomy until the acknowledgement statement has been received.

If the patient needs the Acknowledgement of Hysterectomy Information (Form DMS-2606) in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator. View or print the Americans with Disabilities Act Coordinator contact information.

DIVISION OF MEDICAL SERVICES
STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for
(doctor or clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____
(doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized.

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter *Date*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
Signature of person obtaining consent *Date*

_____
Faculty

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____
Name of individual to be sterilized *Date of sterilization*
_____, I explained to him/her the nature
operation
of the sterilization operation _____, the fact
specify type of operation
that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician
*Date*_____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Medical Services
Checklist for DMS-615 - Sterilization Consent Form

Yes	No	
		Consent To Sterilization
☐	☐	Are all blanks filled in and legible?
☐	☐	Is the recipient's signature present?
☐	☐	Is the date of the signature present?
☐	☐	Was the patient at least 21 years old on the date the consent form was signed?
☐	☐	Is race and ethnicity filled out? (non-mandatory)
☐	☐	Does the recipient have a physical disability? If so, have two witnesses also signed the statement?
		Interpreter's Statement (if applicable)
☐	☐	Are all blanks filled in and legible?
☐	☐	Is the interpreter's signature present?
☐	☐	Is the date of the signature the same as the date of the patient's signature?
		Statement of Person Obtaining Consent
☐	☐	Are all blanks filled in and legible?
☐	☐	Is the signature of the person obtaining consent and date of signature present?
☐	☐	Is the date of the signature the same as the date of the patient's signature? If the date is not the same, it must be after the patient signs, but before the surgery is done.
		Physician's Statement
☐	☐	Are all blanks filled in and legible?
☐	☐	Is the physician signature and date present?
☐	☐	Is the date the physician signed not more than one week prior to surgery?
☐	☐	Have at least 30 days, but not more than 180 days passed between the date of the patient's signature and the date the surgery was done?
		* When counting, do not count the date of the patient's signature as one day. For example, if the patient signed on January 1, thirty days will have passed after January 31.
☐	☐	If 30 days have not passed, does one of the following conditions exist?
		* premature delivery * emergency abdominal surgery
☐	☐	If premature delivery, is the EDC at least 30 days after the date of informed consent?
☐	☐	Is the EDC documented?
☐	☐	Have at least 72 hours (3 days) passed since the date of the patient's signature?
☐	☐	If emergency abdominal surgery, have 72 hours (3 days) passed since the date of the patient's signature?
☐	☐	Are the circumstances described on the physician's statement on the consent form?

DIVISION OF MEDICAL SERVICES
ARKANSAS MEDICAID - TITLE XIX
ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION

ALWAYS COMPLETE THIS SECTION

Beneficiary's Name _____ Medicaid ID # _____

Physician's Name _____ Date of Hysterectomy _____

COMPLETE ONLY ONE OF THE REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION

Section A: Complete this section for beneficiary who acknowledges receipt prior to hysterectomy.
I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

Witness Signature _____ Date _____ Patient's Signature _____ Date _____

Section B: Complete this section when any of the exceptions listed below is applicable.
I certify that before I performed the hysterectomy procedure on the beneficiary listed above: (Check one)

1. [ ] Prior to the hysterectomy being performed, I informed her that this operation would make her permanently incapable of reproducing. (This certification is for retroactively eligible beneficiaries only.)
2. [ ] She was already sterile due to _____ (Cause of Sterility)
3. [ ] She had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe emergency situation:

_____

Physician's Signature _____ Date _____

Section C: Complete this section for mentally-incompetent beneficiary only.
The guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition must be attached to the claim.

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy being performed, that if a hysterectomy is performed on the above beneficiary, it will render her permanently incapable of reproducing.

Witness Signature _____ Date _____ Patient's Representative Signature _____ Date _____

PHYSICIAN'S STATEMENT FOR MENTALLY INCOMPETENT

I affirm that the hysterectomy I performed on the above beneficiary was medically necessary due to

_____
Reason for Hysterectomy

and was not done for sterilization purposes, and that to the best of my knowledge, the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on her, I counseled her representative, orally and in writing, that the hysterectomy would render that individual permanently incapable of reproducing; and, the individual's representative has signed a written acknowledgement of receipt of the foregoing information.

Physician's Signature _____ Date _____

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ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE.
DMS - 2606 (Rev. 4/12)

Instructions for Completing the Acknowledgement of Hysterectomy Statement Form DMS-2606:

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Section A
Must be completed for the beneficiary who acknowledges receipt of information prior to surgery. For beneficiaries with physical disabilities, the Acknowledgement of Hysterectomy statement (Form DMS-2606) must be signed by the patient. If the patient signs with an "X", two witnesses must also sign and include a statement regarding the reason the patient signed with an "X", such as stroke, paralysis, legally blind, etc. This procedure is to be used for patients who do not have intellectual disabilities.

Section B
Must be completed when any of the exceptions listed below exist:

1. Eligibility is retroactive.
2. She was already sterile and the cause of sterility.
3. The hysterectomy was performed because of a life threatening situation and the information concerning sterility could not be given prior to the hysterectomy. The emergency situation must be described.

Section C
Must be completed for the mentally incompetent beneficiary. The guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition must be attached to the claim.

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The acknowledgement statement must be signed by the patient or her representative. The Medicaid agency will not approve payment for any hysterectomy until the acknowledgement statement has been received.

If the patient needs the Acknowledgement of Hysterectomy Information (Form DMS-2606) in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator. View or print the Americans with Disabilities Act Coordinator contact information.