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: **July 15, 2012**

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

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

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.

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Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

211.000 Scope 7-15-12

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 physical 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 7-15-12

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 7-15-12

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

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
216.500	10-13-03	216.500	7-15-12

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.

Andrew Allison, PhD
Director

216.500 Acknowledgement Statement for Hysterectomies and Sterilization Consent Form 7-15-12

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 individuals with intellectual disabilities, 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: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.000	3-1-10	214.000	7-15-12

Explanation of Updates

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

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Andrew Allison, PhD
Director

214.000 Respite Services 7-15-12

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.

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TO: **Arkansas Medicaid Health Care Providers – Developmental Day Treatment Clinic Services**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.131	10-13-03	214.131	7-15-12
214.132	10-13-03	214.132	7-15-12
214.133	10-13-03	214.133	7-15-12

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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Andrew Allison, PhD
Director

214.131 Early Intervention 7-15-12

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 a developmental disability or developmental delay 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 7-15-12

Pre-school service is a facility-based program designed to provide specialized services to children who have been diagnosed with a developmental disability or developmental delay 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 7-15-12

Adult development is a facility-based program providing specialized habilitation services to adults who have been diagnosed with a developmental disability. 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.

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

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
216.410	10-13-03	216.410	7-15-12

Explanation of Updates

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

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Andrew Allison, PhD
Director

216.410 Informed Consent to Sterilization 7-15-12

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 physical 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.

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TO: **Arkansas Medicaid Health Care Providers – Hospital/CAH/End-Stage Renal Disease**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.100	10-13-03	212.100	7-15-12
216.410	10-13-03	216.410	7-15-12

Explanation of Updates

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

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Andrew Allison, PhD
Director

212.100 Scope – Inpatient 7-15-12

"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 7-15-12

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 physical 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
501-682-8368 · Fax: 501-682-2480

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

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
200.100	11-1-09	200.100	7-15-12

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.

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 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (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, notices of rule making 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.

Andrew Allison, PhD
Director

200.100 IndependentChoices 7-15-12

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.

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 – Inpatient Psychiatric Services for Under Age 21**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
215.220	10-13-03	215.220	7-15-12

Explanation of Updates

Section 215.220 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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Andrew Allison, PhD
Director

215.220 Composition of the Facility-Based Team (42 CFR 441.156) 7-15-12

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

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 – Living Choices Assisted Living**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
210.000	10-13-03	210.000	7-15-12
211.100	6-1-09	211.100	7-15-12

Explanation of Updates

Sections 210.000 and 211.100 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.

Andrew Allison, PhD
Director

210.000 PROGRAM COVERAGE 7-15-12

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 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 7-15-12

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 a physical disability 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 an individual with 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 diagnosed with a serious mental illness, except as specified in part C above, or mental retardation are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation 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: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.000	10-15-09	214.000	7-15-12

Explanation of Updates

Section 214.000 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 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (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.

Andrew Allison, PhD
Director

214.000 Eligibility Criteria for QMB Program 7-15-12

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.

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 – Program of All-Inclusive Care for the Elderly (PACE)**

DATE: **July 15, 2012**

SUBJECT: **Provider Manual Update Transmittal PACE-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
204.200	4-1-06	204.200	7-15-12

Explanation of Updates

Section 204.200 is updated to comply with Act 98 - Respectful Language Regarding Disabilities.

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Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

204.200 Medical Criteria 7-15-12

PACE participants must meet one of the following criteria:

The individual is unable to perform either of the following:

A. At least one (1) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,

B. At least two (2) of the three (3) activities of daily living (ADL) of transferring and/or locomotion, eating or toileting without limited assistance from another person;

C. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others;

D. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

NOTE: If an individual has a diagnosis of serious mental illness or mental retardation, the individual will not be eligible for PACE unless the individual has medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meets the criteria set out in Sections 204.100 and 204.200 above.

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 – Personal Care**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
213.540	10-1-07	213.540	7-15-12
217.120	10-13-03	217.120	7-15-12
244.000	10-1-08	244.000	7-15-12

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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Andrew Allison, PhD
Director

213.540 Employment-related Personal Care Outside the Home 7-15-12

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 7-15-12

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 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 7-15-12

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 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

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 – Physician/Independent Lab/CRNA/Radiation Therapy Center**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
251.280	11-1-08	251.280	7-15-12

Explanation of Updates

Section 251.280 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.

Andrew Allison, PhD
Director

251.280 Hysterectomies 7-15-12

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 has a physical 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

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 – Rural Health Clinic**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
217.231	10-13-03	217.231	7-15-12

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.

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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Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

Andrew Allison, PhD
Director

217.231 Informed Consent to Sterilization 7-15-12

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 a physical 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 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: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
261.000	7-1-11	261.000	7-15-12

Explanation of Updates

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

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Andrew Allison, PhD
Director

261.000 Arkansas Medicaid Participation Requirements for DDTCS Transportation Providers 7-15-12

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

Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Section I**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
105.100	9-15-09	105.100	7-15-12
105.160	10-13-03	105.160	7-15-12
122.200	10-13-03	122.200	7-15-12
124.150	9-15-09	124.150	7-15-12
124.160	6-1-08	124.160	7-15-12
124.170	6-1-08	124.170	7-15-12
124.230	9-15-09	124.230	7-15-12

Explanation of Updates

Sections 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.

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105.100 Alternatives for Adults with Physical Disabilities 7-15-12

The Alternatives for Adults with Physical Disabilities (APD) waiver program is for individuals with a physical 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 7-15-12

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 Medicaid-eligible persons aged 21 and older who have been determined by Medicaid to be eligible for an intermediate level of care in a nursing facility. The individual must be a person with a physical disability, blind or elderly.

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 7-15-12

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 permanently and totally disabled categories. The SSI aid categories are listed in Section 124.000.

To be eligible for SSI, an individual must be aged, blind or be an individual with a permanent and total disability. All income, resource and other eligibility criteria must be met.

Individuals entitled to SSI automatically receive Medicaid.

124.150 Qualified Medicare Beneficiaries (QMB) 7-15-12

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 a disability 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) 7-15-12

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 a disability 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) 7-15-12

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 7-15-12

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, with a disability 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	$10 per day

Program Services	New Co-Payment*
Services	
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
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

Program Services	New Co-Payment*
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

Program Development & Quality Assurance

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

DATE: **July 15, 2012**

SUBJECT: **Provider Manual Update Transmittal SecIV-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
400.000	3-1-11	400.000	7-15-12

Explanation of Updates

Section 400.000 is updated to comply with Act 98 – Respectful Language Regarding Disabilities.

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Andrew Allison, PhD
Director

SECTION IV - GLOSSARY

400.000 **7-15-12**

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ABESPA	Arkansas Board of Examiners in Speech-Language Pathology and Audiology
ACD	Augmentative Communication Device
ACIP	Advisory Committee on Immunization Practices
ACES	Arkansas Client Eligibility System
ACS	Alternative Community Services
ADE	Arkansas Department of Education
ADH	Arkansas Department of Health
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children (cash assistance program replaced by the Transitional Employment Assistance (TEA) program)
AFMC	Arkansas Foundation for Medical Care, Inc.
AHEC	Area Health Education Centers
ALF	Assisted Living Facilities
ALS	Advance Life Support
ALTE	Apparent Life Threatening Events
AMA	American Medical Association
APD	Adults with Physical Disabilities
ARS	Arkansas Rehabilitation Services
ASC	Ambulatory Surgical Centers
ASHA	American Speech-Language-Hearing Association
BIPA	Benefits Improvement and Protection Act
BLS	Basic Life Support
CARF	Commission on Accreditation of Rehabilitation Facilities
CCRC	Children’s Case Review Committee
CFA	One Counseling and Fiscal Agent
CFR	Code of Federal Regulations
CHMS	Child Health Management Services
CLIA	Clinical Laboratory Improvement Amendments
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COA	Council on Accreditation
CON	Certification of Need

CPT	Physicians' Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSHCN	Children with Special Health Care Needs
CSWE	Council on Social Work Education
D&E	Diagnosis and Evaluation
DAAS	Division of Aging and Adult Services
DBS	Division of Blind Services (currently named Division of Services for the Blind)
DCFS	Division of Children and Family Services
DCO	Division of County Operations
DD	Developmentally Disabled
DDS	Developmental Disabilities Services
DDTCS	Developmental Day Treatment Clinic Services
DHS	Department of Human Services
DLS	Daily Living Skills
DME	Durable Medical Equipment
DMHS	Division of Mental Health Services
DMS	Division of Medical Services (Medicaid)
DOS	Date of Service
DRG	Diagnosis Related Group
DRS	Developmental Rehabilitative Services
DSB	Division of Services for the Blind (formerly Division of Blind Services)
DSH	Disproportionate Share Hospital
DURC	Drug Utilization Review Committees
DYS	Division of Youth Services
EAC	Estimated Acquisition Cost
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EOB	Explanation of Benefits
EOMB	Explanation of Medicaid Benefits. EOMB may also refer to Explanation of Medicare Benefits.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ESC	Education Services Cooperative
FEIN	Federal Employee Identification Number
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
GUL	Generic Upper Limit
HCBS	Home and Community Based Services

HCPCS	Healthcare Common Procedure Coding System
HDC	Human Development Center
HHS	The Federal Department of Health and Human Services
HIC Number	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HP	Hewlett Packard
IADL	Instrumental Activities of Daily Living
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
ICF/MR	Intermediate Care Facility/Mental Retardation
ICN	Internal Control Number
IDEA	Individuals with Disabilities Education Act
IDG	Interdisciplinary Group
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IMD	Institution for Mental Diseases
IPP	Individual Program Plan
IUD	Intrauterine Devices
JCAHO	Joint Commission on Accreditation of Healthcare Organization
LAC	Licensed Associate Counselor
LCSW	Licensed Certified Social Worker
LEA	Local Education Agencies
LMFT	Licensed Marriage and Family Therapist
LMHP	Licensed Mental Health Practitioner
LPC	Licensed Professional Counselor
LPE	Licensed Psychological Examiner
LSPS	Licensed School Psychology Specialist
LTC	Long Term Care
MAC	Maximum Allowable Cost
MAPS	Multi-agency Plan of Services
MART	Medicaid Agency Review Team
MEI	Medicare Economic Index
MMIS	Medicaid Management Information System
MNIL	Medically Needy Income Limit
MPPPP	Medicaid Prudent Pharmaceutical Purchasing Program
MSA	Metropolitan Statistical Area
MUMP	Medicaid Utilization Management Program
NBCOT	National Board for Certification of Occupational Therapy

NCATE	North Central Accreditation for Teacher Education
NDC	National Drug Code
NET	Non-Emergency Transportation Services
NF	Nursing Facility
NPI	National Provider Identifier
OBRA	Omnibus Budget Reconciliation Act
OHCDS	Organized Health Care Delivery System
OTC	Over the Counter
PA	Prior Authorization
PAC	Provider Assistance Center
PCP	Primary Care Physician
PERS	Personal Emergency Response Systems
PES	Provider Electronic Solutions
PHS	Public Health Services
PIM	Provider Information Memorandum
PL	Public Law
POC	Plan of Care
POS	Place of Service
PPS	Prospective Payment System
PRN	Pro Re Nata or “As Needed”
PRO	Professional Review Organization
ProDUR	Prospective Drug Utilization Review
QMB	Qualified Medicare Beneficiary
QMRP	Qualified Mental Retardation Professional
RA	Remittance Advice. Also called Remittance and Status Report
RFP	Request for Proposal
RHC	Rural Health Clinic
RID	Recipient Identification Number
RSPD	Rehabilitative Services for Persons with Physical Disabilities
RSPMI	Rehabilitation Services for Persons with Mental Illness
RSYC	Rehabilitative Services for Youth and Children
RTC	Residential Treatment Centers
RTP	Return to Provider
RTU	Residential Treatment Units
SBMH	School-Based Mental Health Services
SD	Spend Down
SFY	State Fiscal Year
SMB	Special Low Income Qualified Medicare Beneficiaries

SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SURS	Surveillance and Utilization Review Subsystem
TCM	Targeted Case Management
TEA	Transitional Employment Assistance
TEFRA	Tax Equity and Fiscal Responsibility Act
TOS	Type of Service
TPL	Third Party Liability
UPL	Upper Payment Limit
UR	Utilization Review
VFC	Vaccines for Children
VRS	Voice Response System
Accommodation	A type of hospital room, e.g., private, semiprivate, ward, etc.
Activities of Daily Living (ADL)	Personal tasks that are ordinarily performed on a daily basis and include eating, mobility/transfer, dressing, bathing, toileting and grooming
Adjudicate	To determine whether a claim is to be paid or denied
Adjustments	Transactions to correct claims paid in error or to adjust payments from a retroactive change
Admission	Actual entry and continuous stay of the beneficiary as an inpatient to an institutional facility
Affiliates	Persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another
Agency	The Division of Medical Services
Aid Category	A designation within SSI or state regulations under which a person may be eligible for public assistance
Aid to Families with Dependent Children (AFDC)	A Medicaid eligibility category
Allowed Amount	The maximum amount Medicaid will pay for a service as billed before applying beneficiary coinsurance or co-pay, previous TPL payment, spend down liability or other deducted charges
American Medical Association (AMA)	National association of physicians
Ancillary Services	Services available to a patient other than room and board. For example: pharmacy, X-ray, lab and central supplies
Arkansas Client Eligibility System (ACES)	A state computer system in which data is entered to update assistance eligibility information and beneficiary files
Arkansas Foundation for Medical Care, Inc. (AFMC)	State professional review organization

Attending Physician	*See Performing Physician*.
Automated Eligibility Verification Claims Submission (AEVCS)	On-line system for providers to verify eligibility of beneficiaries and submit claims to fiscal agent
Base Charge	A set amount allowed for a participating provider according to specialty
Beneficiary	Person who meets the Medicaid eligibility requirements, receives an ID card and is eligible for Medicaid services (formerly recipient)
Benefits	Services available under the Arkansas Medicaid Program
Billed Amount	The amount billed to Medicaid for a rendered service
Buy-In	A process whereby the state enters into an agreement with the Medicaid/Medicare and the Social Security Administration to obtain Medicare Part B (and part A when needed) for Medicaid beneficiaries who are also eligible for Medicare. The state pays the monthly Medicare premium(s) on behalf of the beneficiary.
Care Plan	*See Plan of Care (POC).*
Casehead	An adult responsible for an AFDC or Medicaid child
Categorically Needy	All individuals receiving financial assistance under the state's approved plan under Title I, IV-A, X, XIV and XVI of the Social Security Act or in need under the state's standards for financial eligibility in such a plan
Centers for Medicare and Medicaid Services	Federal agency that administers federal Medicaid funding
Child Health Services	Arkansas Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
Children's Services	A Title V Children with Special Health Care Needs Program administered by the Arkansas Division of Developmental Disabilities Services to provide medical care and service coordination to children with chronic physical illnesses or disabilities.
Claim	A request for payment for services rendered
Claim Detail	*See Line Item*.
Clinic	(1) A facility for diagnosis and treatment of outpatients. (2) A group practice in which several physicians work together
Coinsurance	The portion of allowed charges the patient is responsible for under Medicare. This may be covered by other insurance, such as Medi-Pak or Medicaid (if entitled). This also refers to the portion of a Medicaid covered inpatient hospital stay for which the beneficiary is responsible.
Contract	Written agreement between a provider of medical services and the Arkansas Division of Medical Services. A contract must be signed by each provider of services participating in the Medicaid Program.
Co-pay	The portion of the maximum allowable (either that of Medicaid or a third-party payer) that the insured or beneficiary must pay
Cosmetic Surgery	Any surgical procedure directed at improving appearance but not medically necessary
Covered Service	Service which is within the scope of the Arkansas Medicaid Program

Current Procedural Terminology	A listing published annually by AMA consisting of current medical terms and the corresponding procedure codes used for reporting medical services and procedures performed by physicians
Credit Claim	A claim transaction which has a negative effect on a previously processed claim.
Crossover Claim	A claim for which both Titles XVIII (Medicare) and XIX (Medicaid) are liable for reimbursement of services provided to a beneficiary entitled to benefits under both programs
Date of Service	Date or dates on which a beneficiary receives a covered service. Documentation of services and units received must be in the beneficiary's record for each date of service.
Deductible	The amount the Medicare beneficiary must pay toward covered benefits before Medicare or insurance payment can be made for additional benefits. Medicare Part A and Part B deductibles are paid by Medicaid within the program limits.
Debit Claim	A claim transaction which has a positive effect on a previously processed claim
Denial	A claim for which payment is disallowed
Department of Health and Human Services (HHS)	Federal health and human services agency
Department of Human Services (DHS)	State human services agency
Dependent	A spouse or child of the individual who is entitled to benefits under the Medicaid Program
Diagnosis	The identity of a condition, cause or disease
Diagnostic Admission	Admission to a hospital primarily for the purpose of diagnosis
Disallow	To subtract a portion of a billed charge that exceeds the Medicaid maximum or to deny an entire charge because Medicaid pays Medicare Part A and B deductibles subject to program limitations for eligible beneficiaries
Discounts	A discount is defined as the lowest available price charged by a provider to a client or third-party payer, including any discount, for a specific service during a specific period by an individual provider. If a Medicaid provider offers a professional or volume discount to any customer, claims submitted to Medicaid must reflect the same discount. Example: If a laboratory provider charges a private physician or clinic a discounted rate for services, the charge submitted to Medicaid for the same service must not exceed the discounted price charged to the physician or clinic. Medicaid must be given the benefit of discounts and price concessions the lab gives any one of its customers.
Duplicate Claim	A claim that has been submitted or paid previously or a claim that is identical to a claim in process
Durable Medical Equipment	Equipment that (1) can withstand repeated use and (2) is used to serve a medical purpose. Examples include a wheelchair or hospital bed.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A federally mandated Medicaid program for eligible individuals under the age of 21. *See Child Health Services*.
Education Accreditation	When an individual is required to possess a bachelor's degree, master's degree, or a Ph.D. degree in a specific profession. The degree must be from a program accredited by an organization that is approved by the Council for Higher Education Accreditation (CHEA).
Electronic Signature	An electronic or digital method executed or adopted by a party with the intent to be bound by or to authenticate a record, which is: (a) Unique to the person using it; (b) Capable of verification; (c) Under the sole control of the person using it; and (d) Linked to data in such a manner that if the data are changed the electronic signature is invalidated. An Electronic Signature method must be approved by the DHS Chief Information Officer or his designee before it will be accepted. A list of approved electronic signature methods will be posted on the state Medicaid website.
Eligible	(1) To be qualified for Medicaid benefits. (2) One who is qualified for benefits
Eligibility File	A file containing individual records for all persons who are eligible or have been eligible for Medicaid
Emergency Services	Inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services. Source: 42 U.S. Code of Federal Regulations (42 CFR) and §424.101.
Error Code	A numeric code indicating the type of error found in processing a claim; also known as an "Explanation of Benefits (EOB) code" or a "HIPAA Explanation of Benefits (HEOB) code"
Estimated Acquisition Cost	The estimated amount a pharmacy actually pays to obtain a drug
Experimental Surgery	Any surgical procedure considered experimental in nature
Explanation of Medicaid Benefits (EOMB)	A statement mailed once per month to selected beneficiaries to allow them to confirm the Medicaid service which they received
Family Planning Services	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician, nurse practitioner, certified nurse-midwife, pharmacy, hospital, family planning clinic, rural health clinic (RHC), Federally Qualified Health Center (FQHC) or the Department of Health to individuals of child-bearing age for purposes of enabling such individuals freedom to determine the number and spacing of their children.
Field Audit	An activity performed whereby a provider's facilities, procedures, records and books are audited for compliance with Medicaid regulations and standards. A field audit may be conducted on a routine basis, or on a special basis announced or unannounced.
Fiscal Agent	An organization authorized by the State of Arkansas to process Medicaid claims

Fiscal Agent Intermediary	A private business firm which has entered into a contract with the Arkansas Department of Human Services to process Medicaid claims
Fiscal Year	The twelve-month period between settlements of financial accounts
Generic Upper Limit (GUL)	The maximum drug cost that may be used to compute reimbursement for specified multiple-source drugs unless the provisions for a Generic Upper Limit override have been met. The Generic Upper Limit may be established or revised by the Centers for Medicare and Medicaid Services (CMS) or by the State Medicaid Agency.
Group	Two or more persons. If a service is a "group" therapy or other group service, there must be two or more persons present and receiving the service.
Group Practice	A medical practice in which several practitioners render and bill for services under a single pay-to provider identification number
Healthcare Common Procedure Coding System (HCPCS)	Federally defined procedure codes
Health Insurance Claim Number	Number assigned to Medicare beneficiaries and individuals eligible for SSI
Hospital	An institution that meets the following qualifications: • Provides diagnostic and rehabilitation services to inpatients • Maintains clinical records on all patients • Has by-laws with respect to its staff of physicians • Requires each patient to be under the care of a physician, dentist or certified nurse-midwife • Provides 24-hour nursing service • Has a hospital utilization review plan in effect • Is licensed by the State • Meets other health and safety requirements set by the Secretary of Health and Human Services
Hospital-Based Physician	A physician who is a hospital employee and is paid for services by the hospital
HP Enterprise Services	Current fiscal agent for the state Medicaid program
ID Card	An identification card issued to Medicaid beneficiaries and ARKids First-B participants containing encoded data that permits a provider to access the card-holder's eligibility information
Individual	A single person as distinguished from a group. If a service is an "individual" therapy or service, there may be only one person present who is receiving the service.
Inpatient	A patient, admitted to a hospital or skilled nursing facility, who occupies a bed and receives inpatient services.
In-Process Claim (Pending Claim)	A claim that suspends during system processing for suspected error conditions such as: all processing requirements appear not to be met. These conditions must be reviewed by HP ENTERPRISE SERVICES or DMS and resolved before processing of the claim can be completed. *See Suspended Claim*.
Inquiry	A request for information

Institutional Care	Care in an authorized private, non-profit, public or state institution or facility. Such facilities include schools for the deaf, and/or blind and institutions for individuals with disabilities.
Instrumental Activities of Daily Living (IADL)	Tasks which are ordinarily performed on a daily or weekly basis and include meal preparation, housework, laundry, shopping, taking medications and travel/transportation
Intensive Care	Isolated and constant observation care to patients critically ill or injured
Interim Billing	A claim for less than the full length of an inpatient hospital stay. Also, a claim that is billed for services provided to a particular date even though services continue beyond that date. It may or may not be the final bill for a particular beneficiary's services.
Internal Control Number (ICN)	The unique 13-digit claim number that appears on a Remittance Advice
International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9CM)	A diagnosis coding system used by medical providers to identify a patient's diagnosis and/or diagnoses on medical records and claims
Investigational Product	Any product that is considered investigational or experimental and that is not approved by the Food and Drug Administration. The Arkansas Medicaid Program does not cover investigational products.
Julian Date	Chronological date of the year, 001 through 365 or 366, preceded on a claims number (ICN) by a two-digit-year designation. Claim number example: 03231 (August 19, 2003).
Length Of Stay	Period of time a patient is in the hospital. Also, the number of days covered by Medicaid within a single inpatient stay.
Limited Services Provider Agreement	An agreement for a specific period of time not to exceed 12 months, which must be renewed in order for the provider to continue to participate in the Title XIX Program.
Line Item	A service provided to a beneficiary. A claim may be made up of one or more line items for the same beneficiary. Also called a claim detail.
Long Term Care (LTC)	An office within the Arkansas Division of Medical Services responsible for nursing facilities
Long Term Care Facility	A nursing facility
Maximum Allowable Cost (MAC)	The maximum drug cost which may be reimbursed for specified multi-source drugs. This term is interchangeable with generic upper limit.
Medicaid Provider Number	A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program, required for identification purposes
Medicaid Management Information System (MMIS)	The automated system utilized to process Medicaid claims
Medical Assistance Section	A section within the Arkansas Division of Medical Services responsible for administering the Arkansas Medical Assistance Program

Medically Needy	Individuals whose income and resources exceed the levels for assistance established under a state or federal plan for categorically needy, but are insufficient to meet costs of health and medical services
Medical Necessity	All Medicaid benefits are based upon medical necessity. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental inappropriate or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary.
Mis-Utilization	Any usage of the Medicaid Program by any of its providers and/or beneficiaries which is not in conformance with both State and Federal regulations and laws (includes fraud, abuse and defects in level and quality of care)
National Drug Code	The unique 11-digit number assigned to drugs which identifies the manufacturer, drug, strength and package size of each drug
National Provider Identifier (NPI)	A standardized unique health identifier for health care providers for use in the health care system in connection with standard transactions for all covered entities. Established by the Centers for Medicare & Medicaid Services, HHS, in compliance with HIPAA Administrative Simplification – 45 CFR Part 162.
Non-Covered Services	Services not medically necessary, services provided for the personal convenience of the patient or services not covered under the Medicaid Program
Nonpatient	An individual who receives services, such as laboratory tests, performed by a hospital, but who is not a patient of the hospital
Nurse Practitioner	A professional nurse with credentials that meet the requirements for licensure as a nurse practitioner in the State of Arkansas
Outpatient	A patient receiving medical services, but not admitted as an inpatient to a hospital
Over-Utilization	Any over usage of the Medicaid Program by any of its providers and/or beneficiaries not in conformance with professional judgment and both State and Federal regulations and laws (includes fraud and abuse)
Participant	A provider of services who: (1) provides the service, (2) submits the claim and (3) accepts Medicaid's reimbursement for the services provided as payment in full
Patient	A person under the treatment or care of a physician or surgeon, or in a hospital
Payment	Reimbursement to the provider of services for rendering a Medicaid-covered benefit

Pay-to Provider	A person, organization or institution authorized to receive payment for services provided to Medicaid beneficiaries by a person or persons who are a part of the entity
Pay-to Provider Number	A unique identifying number assigned to each pay-to provider of services (Clinic/Group/Facility) in the Arkansas Medicaid Program or the pay-to provider group's assigned National Provider Identifier (NPI). Medicaid reports provider payments to the Internal Revenue Service under the Employer Identification Number "Tax ID" linked in the Medicaid Provider File to the pay-to provider identification number.
Per Diem	A daily rate paid to institutional providers
Performing Physician	The physician providing, supervising, or both, a medical service and claiming primary responsibility for ensuring that services are delivered as billed
Person	Any natural person, company, firm, association, corporation or other legal entity
Place of Service (POS)	A nationally approved two-digit numeric code denoting the location of the patient receiving services
Plan of Care	A document utilized by a provider to plan, direct or deliver care to a patient to meet specific measurable goals; also called care plan, service plan or treatment plan
Postpayment Utilization Review	The review of services, documentation and practice after payment
Practitioner	An individual who practices in a health or medical service profession
Prepayment Utilization Review	The review of services, documentation and practice patterns before payment
Prescription	A health care professional's legal order for a drug which, in accordance with federal and/or state statutes, may not be obtained otherwise; also an order for a particular Medicaid covered service
Prescription Drug (RX)	A drug which, in accordance with federal and/or state statutes, may not be obtained without a valid prescription
Primary Care Physician (PCP)	A physician responsible for the management of a beneficiary's total medical care. Selected by the beneficiary to provide primary care services and health education. The PCP will monitor on an ongoing basis the beneficiary's condition, health care needs and service delivery be responsible for locating, coordinating and monitoring medical and rehabilitation services on behalf of the beneficiary and refer the beneficiary for most specialty services, hospital care and other services.
Prior Approval	The approval for coverage and reimbursement of specific services prior to furnishing services for a specified beneficiary of Medicaid. The request for prior approval must be made to the Medical Director of the Division of Medical Services for review of required documentation and justification for provision of service.
Prior Authorization (PA)	The approval by the Arkansas Division of Medical Services, or a designee of the Division of Medical Services, for specified services for a specified beneficiary to a specified provider before the requested services may be performed and before payment will be made. **Prior authorization does not guarantee reimbursement.**
Procedure Code	A five-digit numeric or alpha numeric code to identify medical services and procedures on medical claims

Professional Component	A physician's interpretation or supervision and interpretation of laboratory, X-ray or machine test procedures
Profile	A detailed view of an individual provider's charges to Medicaid for health care services or a detailed view of a beneficiary's usage of health care services
Provider	A person, organization or institution enrolled to provide and be reimbursed for health or medical care services authorized under the State Title XIX Medicaid Program
Provider Identification Number	A unique identifying number assigned to each provider of services in the Arkansas Medicaid Program or the provider's assigned National Provider Identifier (NPI), when applicable, that is required for identification purposes
Provider Relations	The activity within the Medicaid Program which handles all relationships with Medicaid providers
Quality Assurance	Determination of quality and appropriateness of services rendered
Quality Improvement Organization	A Quality Improvement Organization (QIO) is a federally mandated review organization required of each state's Title XIX (Medicaid) program. Arkansas Medicaid has contracted with the Arkansas Foundation for Medical Care, Inc. (AFMC) to be its QIO. The QIO monitors hospital and physician services billed to the state's Medicare intermediary and the Medicaid program to assure high quality, medical necessity and appropriate care for each patient's needs.
Railroad Claim Number	The number issued by the Railroad Retirement Board to control payments of annuities and pensions under the Railroad Retirement Act. The claim number begins with a one- to three-letter alphabetic prefix denoting the type of payment, followed by six or nine numeric digits.
Referral	An authorization from a Medicaid enrolled provider to a second Medicaid enrolled provider. The receiving provider is expected to exercise independent professional judgment and discretion, to the extent permitted by laws and rules governing the practice of the receiving practitioner, and to develop and deliver medically necessary services covered by the Medicaid program. The provider making the referral may be a physician or another qualified practitioner acting within the scope of practice permitted by laws or rules. Medicaid requires documentation of the referral in the beneficiary's medical record, regardless of the means the referring provider makes the referral. Medicaid requires the receiving provider to document the referral also, and to correspond with the referring provider regarding the case when appropriate and when the referring provider so requests.
Reimbursement	The amount of money remitted to a provider
Rejected Claim	A claim for which payment is refused
Relative Value	A weighting scale used to relate the worth of one surgical procedure to any other. This evaluation, expressed in units, is based upon the skill, time and the experience of the physician in its performance.
Remittance	A remittance advice
Remittance Advice (RA)	A notice sent to providers advising the status of claims received, including paid, denied, in-process and adjusted claims. It includes year-to-date payment summaries and other financial information.
Reported Charge	The total amount submitted in a claim detail by a provider of services for reimbursement

Retroactive Medicaid Eligibility	Medicaid eligibility which may begin up to three (3) months prior to the date of application provided all eligibility factors are met in those months
Returned Claim	A claim which is returned by the Medicaid Program to the provider for correction or change to allow it to be processed properly
Sanction	Any corrective action taken against a provider
Screening	The use of quick, simple medical procedures carried out among large groups of people to sort out apparently well persons from those who may have a disease or abnormality and to identify those in need of more definitive examination or treatment
Signature	The person's original signature or initials. The person's signature or initials may also be recorded by an electronic or digital method, executed or adopted by the person with the intent to be bound by or to authenticate a record. An electronic signature must comply with Arkansas Code Annotated § 25-31-101-105, including verification through an electronic signature verification company and data links invalidating the electronic signature if the data is changed.
Single State Agency	The state agency authorized to administer or supervise the administration of the Medicaid Program on a statewide basis
Skilled Nursing Facility (SNF)	A nursing home, or a distinct part of a facility, licensed by the Office of Long Term Care as meeting the Skilled Nursing Facility Federal/State licensure and certification regulations. A health facility which provides skilled nursing care and supportive care on a 24-hour basis to residents whose primary need is for availability of skilled nursing care on an extended basis.
Social Security Administration (SSA)	A federal agency which makes disability and blindness determinations for the Secretary of the HHS
Social Security Claim Number	The account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is the Social Security Account Number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (e.g., wife, widow, child, etc.).
Source of Care	A hospital, clinic, physician or other facility which provides services to a beneficiary under the Medicaid Program
Specialty	The specialized area of practice of a physician or dentist
Spend Down (SD)	The amount of money a beneficiary must pay toward medical expenses when income exceeds the Medicaid financial guidelines. A component of the medically needy program allows an individual or family whose income is over the medically needy income limit (MNIL) to use medical bills to spend excess income down to the MNIL. The individual(s) will have a spend down liability. The spend down column of the remittance advice indicates the amount which the provider may bill the beneficiary. The spend down liability occurs only on the first day of Medicaid eligibility.
Status Report	A remittance advice
Supplemental Security Income (SSI)	A program administered by the Social Security Administration. This program replaced previous state administered programs for aged, blind or individuals with disabilities (except in Guam, Puerto Rico and the Virgin Islands). This term may also refer to the Bureau of Supplemental Security Income within SSA which administers the program.
Suspended Claim	An "In-Process Claim" which must be reviewed and resolved

Suspension from Participation	An exclusion from participation for a specified period of time
Suspension of Payments	The withholding of all payments due to a provider until the resolution of a matter in dispute between the provider and the state agency
Termination from Participation	A permanent exclusion from participation in the Title XIX Program
Third Party Liability (TPL)	A condition whereby a person or an organization, other than the beneficiary or the state agency, is responsible for all or some portion of the costs for health or medical services incurred by the Medicaid beneficiary (e.g., a health insurance company, a casualty insurance company or another person in the case of an accident, etc.).
Utilization Review (UR)	The section of the Arkansas Division of Medical Services which performs the monitoring and controlling of the quantity and quality of health care services delivered under the Medicaid Program
Void	A transaction which deletes
Voice Response System (VRS)	Voice-activated system to request prior authorization for prescription drugs and for PCP assignment and change
Ward	An accommodation of five or more beds
Withholding of Payments	A reduction or adjustment of the amounts paid to a provider on pending and subsequently due payments
Worker's Compensation	A type of Third Party Liability for medical services rendered as the result of an on-the-job accident or injury to a beneficiary for which the employer's insurance company may be obligated under the Worker's Compensation Act

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 – Section V**

DATE: **July 15, 2012**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
DMS-615	4-96	DMS-615	7-12
DMS-2606	4-07	DMS-2606	7-12

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.**

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 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (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.

Andrew Allison, PhD
Director

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)
☐	☐	Is the recipient an individual with 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 _____

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. 7/12)

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.