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: **January 1, 2013**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
203.000	7-22-10	203.000	1-1-13
213.000	2-1-11	213.000	1-1-13
213.310	7-22-10	213.310	1-1-13
214.000	10-13-03	214.000	1-1-13
214.100	10-1-07	214.100	1-1-13
214.110	10-13-03	214.110	1-1-13
214.200	10-13-03	214.200	1-1-13
214.300	7-22-10	214.300	1-1-13
214.310	7-22-10	214.310	1-1-13
214.320	7-22-10	214.320	1-1-13
214.400	7-22-10	214.400	1-1-13
215.100	3-1-08	215.100	1-1-13
215.330	10-13-03	215.330	1-1-13
216.000	10-1-07	216.000	1-1-13
216.400	10-13-03	216.400	1-1-13
217.120	7-15-12	217.120	1-1-13
220.110	3-1-08	220.110	1-1-13
221.000	3-1-08	221.000	1-1-13
222.100	10-13-03	222.100	1-1-13
222.110	10-13-03	222.110	1-1-13
222.120	10-13-03	222.120	1-1-13
222.130	10-13-03	222.130	1-1-13
222.140	10-13-03	222.140	1-1-13
244.000	7-15-12	244.000	1-1-13

Explanation of Updates

Sections 203.000, 213.000, 213.310, 214.000, 214.100, 214.110, 214.200, 214.300, 214.310, 214.320, 214.400, 215.100, 215.330, 216.000, 216.400, 217.120, 220.110, 221.000, 222.100, 222.110, 222.120, 222.130, 222.140 and 244.000 are updated to reflect the most current rules and regulations for the Personal Care program.

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

TOC required

203.000 IndependentChoices 1-1-13

IndependentChoices began as a Cash and Counseling Demonstration and Evaluation Project. IndependentChoices seeks to increase the opportunity for consumer direction and control for Medicaid beneficiaries receiving or needing personal care by offering a cash allowance and counseling services in place of traditionally provided personal care. IndependentChoices and how it related to the Personal Care State Plan program is referenced in this manual and the IndependentChoices provider manual.

213.000 Scope of the Program 1-1-13

A. Personal care services are primarily based on the assessed physical dependency need for "hands-on" services with the following activities of daily living (ADL): eating, bathing, dressing, personal hygiene, toileting and ambulating. Hands-on assistance in at least one of these areas is required. This type of assistance is provided by a personal care aide based on a beneficiary's physical dependency needs (as opposed to purely housekeeping services). A plan of care is developed through the assessment process and is based on a beneficiary's dependency in at least one of the above-listed activities of daily living. While not a part of the eligibility criteria, the need for assistance with other tasks and IADLs (Instrumental Activities of Daily Living) are considered in the assessment. Both types of assistance are considered when determining the amount of overall personal care assistance authorized. Routines or IADLs include meal preparation, incidental housekeeping, laundry, medication assistance, etc. These tasks are also defined and described in this section of this provider manual.

B. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the beneficiary were in a hospital or nursing facility.

C. Personal care services may be similar to or overlap some services that home health aides furnish.

1. Home health aides may provide personal care services in the home under the home health benefit.
2. Skilled services that only a health professional may perform are not considered personal care services.

D. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:

1. Authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by the State, e.g., ElderChoices, IndependentChoices;
2. Furnished in the beneficiary's home, and at the State's option, in another location.
3. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family".

E. Personal care for Medicaid-eligible individuals under the age of 21 requires prior authorization. See Sections 240.000 through 246.000.

F. Only Class A Home Health agencies, Class B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, education service cooperatives and DDS facilities may provide

personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

213.310 IndependentChoices Program, Title XIX State Plan Program 1-1-13

IndependentChoices is operated by the Division of Aging and Adult Services (DAAS) and operates under the authority of the Title XIX State Plan with the Division of Medical Services responsible for administrative and financial authority.

IndependentChoices offers an opportunity to Medicaid-eligible adults with disabilities (age 18 and older) and the elderly (age 65 and older) to direct their personal care. The beneficiary chooses a cash allowance in lieu of agency personal care services. IndependentChoices provides qualifying beneficiaries with counseling and training to assist them with information to fulfill their role as an employer. The beneficiary as the employer will hire, train, supervise and, if necessary, terminate the services of their employee. In addition to hiring an employee, the beneficiary may use part of their budget to purchase goods and services that lessen their physical dependency needs. In addition to counseling support services, participants may receive Financial Management Services (FMS) from a DMS contracted provider. The FMS provider will assist the participant by processing timesheets, withholding and reporting State and Federal taxes, issuing a W-2 to all employees who meet the tax threshold and refunding taxes to the participant and the employee when the threshold was not met. The FMS provider also coordinates the accuracy and coordination of the forms used to establish the Medicaid beneficiary as an employer and to employ a worker. The FMS provider representing the Medicaid beneficiary will obtain permissions and execute an IRS Form 2678 to act as the beneficiary's agent.

NOTE: The IndependentChoices Program is required to follow the rules and regulations of the State Plan approved Personal Care Program, unless stated otherwise in this manual.

214.000 The Physician's Role in Personal Care 1-1-13

A. A personal care service plan is designed to direct an appropriate amount of individual assistance to a beneficiary's physical dependency needs.

B. The physician is essential to the determination of what constitutes an appropriate amount of assistance.

1. The physician evaluates the relationships among the beneficiary's health status, physical dependency needs and daily routines and activities.
2. The physician helps the beneficiary and the personal care provider design an individualized plan to address the beneficiary's individual physical dependencies.

C. Personal care services may commence on or after the date of the beneficiary's attending physician's signature on an individualized personal care service plan, authorizing the services.

1. The beneficiary's attending physician is responsible for the decision to authorize personal care services.
2. The beneficiary's attending physician must be the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP requirements.
    a. In this manual, "physician" and "attending physician" both mean "the physician primarily responsible for the medical management of the patient," unless they are otherwise defined in a particular context.
    b. "Primary care physician" and "PCP" are explained in Section I of this manual.

214.100 Physician Authorization of Personal Care Services 1-1-13

A. An individualized personal care service plan signed (original signature) and dated by the beneficiary's PCP or attending physician, constitutes the physician's personal care authorization. Services may continue uninterrupted as long as the services are reauthorized prior to the expiration of the current service plan end date. The uninterrupted continuation is also dependent upon the physician having a face-to-face visit with the beneficiary within 60 days prior to the date that the physician signs the service plan. If the physician informs that he or she had not seen the beneficiary in the past 60 days, the beneficiary is expected to have the face-to-face visit prior to the beginning of the new service plan begin date. Should this not occur, personal care services must be discontinued until the face-to-face visit occurs unless for health and safety reasons the physician requests in writing that personal care services continue and informs of the date the face-to-face visit is scheduled. Should the services be discontinued, the requesting provider is required to resubmit page 6 of the DMS-618 to the physician asking that the physician make a correction to the date field and initial the date services are reauthorized per the most recent face-to-face visit. When services are interrupted, the corrected date represents the new begin date of the service plan.

1. The attending physician and the beneficiary must have a face-to-face visit before the physician may authorize personal care services, unless the physician has seen the beneficiary within the 60 days preceding the beginning date of service established in the proposed service plan or 60 days prior to the date the physician signs the DMS-618.
2. The attending physician must review the assessment and service plan to ensure that the personal care aide's assigned tasks appropriately address the beneficiary's individual physical dependency needs.
3. Based on the assessment and the physician's medical evaluation, the attending physician must authorize only individualized personal care services that constitute medically necessary assistance with the beneficiary's physical dependency needs in the beneficiary's home or other authorized locations rather than in an institution.

B. The personal care service plan authorized by the physician must specify the following items.

1. The date services are to begin (may not be earlier than the date of the physician’s signature.)
2. The duration of need for services
3. The expected results of the services

C. Personal care services may not begin initially before the date the beneficiary's attending physician signs the individualized personal care service plan.

D. Services may not commence before the beginning date of service established by the authorized service plan.

E. The physician may change the frequency, scope or duration of service in the service plan.

F. The physician may add to, delete from or otherwise modify the service plan.

G. The physician's authorization of the service plan must be by dated original signature only. A stamp or signature initialed by a *locum tenens* is the only acceptable substitute for an original signature by the attending physician.

H. The physician must date and sign or initial any revisions to the service plan, as well as any attachments he or she adds to the service plan.

I. The physician must maintain a copy of the signed service plan and signed copies of any subsequent authorized service plan revisions with the beneficiary's permanent medical record.

214.110 The Physician's Notification of Service Plan Authorization 1-1-13

The physician may communicate the authorization of a service plan by telephone, fax or e-mail to expedite service delivery.

A. If the service plan is transmitted via fax, the facsimile copy of the physician's original signature satisfies the "original signature" requirement (see Section 214.100, part G). The physician must maintain the original document with the original signature(s) in his or her files.

B. If the service plan is communicated by telephone, the physician must forward the completed authorized service plan with original signature and authorization date to the personal care provider no later than 14 working days following the authorized beginning date of personal care service.

NOTE: Throughout this manual, it is emphasized that services may not begin until the date of the physician's signature authorizing services. When services begin based on a verbal authorization from the physician, and a written authorization with the physician's signature is received within the 14 day timeframe, the authorization must clearly state the date services were authorized based on the verbal order. Rarely, if ever, will the date of the verbal order and the date of the written order be the same, however, the authorization date must be clearly documented and linked to the verbal order if services begin prior to the date of the physician's signature.

214.200 Service Plan Review and Renewal 1-1-13

A. A personal care service plan terminates six (6) months after its initial or revised beginning date of service, unless described otherwise in this section. See **NOTE** below.

1. The beneficiary's physician must review the service plan no less often than every six months, unless described otherwise in this section. See **NOTE** below.
2. Upon completion of the six-month review, the physician may authorize continued personal care services, either unchanged or with modifications; or the physician may order that services cease.

B. Personal care services may not continue past the six-month anniversary of an initial or revised beginning date of service until the beneficiary's physician authorizes a revised service plan or renews the authorization of an existing service plan.

NOTE: Under specific circumstances, a service plan may be authorized for more than six (6) months, not to exceed one year. If the physician's authorization for personal care services is based on a CHRONIC CONDITION that will not improve within the next six (6) months, the service plan may be authorized for more than six (6) months, not to exceed one year. The physician must sign the service plan and documentation must be included on the service plan verifying the chronic condition and the lack of expected improvement over the length of the service plan.

NOTE: An advanced practice nurse (APN) enrolled in the Arkansas Medicaid Program seeing patients in a Rural Health Clinic or Federally Qualified Health Center enrolled in the Arkansas Medicaid Program as an RHC or FQHC may sign the personal care service plan/order if practicing within an environment for which his/her certification applies and within the scope of

his/her certification. No MD signature is required in addition to the APN's signature unless required by their license and/or certification.

214.300 Authorization of ElderChoices Plan of Care and Personal Care Service Plan 1-1-13

The DAAS RN is responsible for developing an ElderChoices Plan of Care that includes both waiver and non-waiver services. Once developed, the Plan of Care is signed by the DAAS RN authorizing the services listed.

The signed ElderChoices Plan of Care will suffice as the " Personal Care Authorization" for services required in the Personal Care Program. The signature of the DAAS RN on the ElderChoices Plan of Care simply replaces the need for the physician's signature authorizing personal care services. The personal care service plan, developed by the Personal Care provider, is still required.

As the ElderChoices Plan of Care is effective for one year, once signed by the DAAS RN; the authorization for personal care services, when included on the ElderChoices Plan of Care, will be for one year from the date of the DAAS RN's signature, unless revised by the DAAS RN or the personal care service plan needs to be revised, whichever occurs first. If personal care services continue unchanged as authorized on the ElderChoices Plan of Care, a new service plan is not required at the 6-month interval.

NOTE: For ElderChoices participants who receive personal care through traditional agency services or have chosen to receive their personal care services through the IndependentChoices Program, the ElderChoices plan of care, signed by a DAAS RN, will serve as the authorization for personal care services for one year from the date of the DAAS RN's signature, as described above.

The responsibility of developing a personal care service plan is not placed with the DAAS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

The Arkansas Medicaid Program waives no other Personal Care Program requirements with regard to personal care service plan authorizations obtained by DAAS RNs.

214.310 Development of ElderChoices Plan of Care 1-1-13

If personal care services are not currently being provided when the DAAS RN develops the ElderChoices Plan of Care, the DAAS RN will determine if personal care services are needed. If so, the service, amount, frequency, duration and the recipient's provider of choice will be included on the ElderChoices Plan of Care. A copy of the ElderChoices Plan of Care and a Start of Care form (AAS-9510) will be forwarded to the personal care provider, as is current practice for waiver services. The Start of Care form must be returned to the DAAS RN within 10 working days from mailing or action may be taken by the DAAS RN to secure another personal care provider or modify the ElderChoices Plan of Care. (The ElderChoices Plan of Care is dated the date it is mailed.) Before taking action to secure another provider or modifying the Plan of Care, the applicant and/or family members will be contacted to discuss possible alternatives. Communications related to participation in the IndependentChoices program will be conveyed electronically through "tasks" communicated through Med Compass software, a new data system used to help manage waiver and IndependentChoices services.

This Plan of Care supersedes any other Plan of Care that may have been previously developed by another Medicaid provider for the applicant. The ElderChoices Plan of Care must include all appropriate ElderChoices services and certain non-waiver services appropriate for the applicant, such as Personal Care.

An agency providing services to an ElderChoices beneficiary must report these services to the DAAS RN. The services being provided to the ElderChoices beneficiary must be included on the ElderChoices Plan of Care. Prior to beginning services or revising services provided to an ElderChoices beneficiary, contact the DAAS RN so the Plan of Care is properly revised and approved. Please report all changes in services and changes in the ElderChoices beneficiary's circumstances to the DAAS RN immediately upon learning of the change. Certain services provided to an ElderChoices beneficiary that are not included on the ElderChoices Plan of Care may be subject to recoupment by the Medicaid Program.

If the DAAS RN is aware that personal care services are currently being provided when the ElderChoices Plan of Care is developed, the DAAS RN will contact the personal care provider to verify the current order and amount of personal care services in place If requested verbally, the request must be documented in the ElderChoices nurse narrative. It is the personal care provider's responsibility to provide the requested information to the DAAS RN immediately upon receipt of the request. If a copy is not received within 10 working days of the request, the DAAS RN will process the ElderChoices Plan of Care, as developed by the DAAS RN.

NOTE: It is the IndependentChoices employer or personal care provider's responsibility to place information regarding their presence in the home in a prominent location so that the DAAS RN will be aware that they are serving the beneficiary. Preferably, the provider will place the information on the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will place the information in a location satisfactory to the applicant, as long as it is readily available and easily accessible by the DAAS RN.

The personal care service plan developed by the personal care provider must meet all requirements as detailed in the personal care provider manual. This includes, but is not limited to, the amount of personal care services, personal care tasks, frequency and duration. The DAAS RN will not alter the current number of personal care units, unless a waiver Plan of Care cannot be developed without duplicating services. If personal care units must be altered, the DAAS RN will contact the personal care provider to discuss available alternatives prior to making any revisions. The ElderChoices Plan of Care and the required justification for each service remains the responsibility of the DAAS RN. Therefore, final decisions regarding services included on the ElderChoices Plan of Care rest with the DAAS RN.

NOTE: For the IndependentChoices program, services are effective the date of the DAAS RN's signature on the assessment tool or the waiver plan of care, whichever is the latter of the two.

214.320 Revisions to the ElderChoices Plan of Care 1-1-13

Requested changes to the personal care services included on the ElderChoices Plan of Care may originate with the personal care RN or the DAAS RN, based on the recipient's circumstances. Unless requested by an IndependentChoices beneficiary, the individual or agency requesting revisions to the Personal Care services on the ElderChoices Plan of Care is responsible for securing any required signatures authorizing the change prior to the ElderChoices Plan of Care being revised. The DAAS RN will obtain electronic signatures for dates of service on or after January 1, 2013.

If revised by the DAAS RN, a copy of the revised ElderChoices Plan of Care and a Start of Care Form (AAS-9510) will be mailed to the personal care provider within 10 working days after being revised. If authorization is secured by the Personal Care agency, a copy of the revised personal care order, signed by the physician, must be sent to the DAAS RN prior to implementing any revisions. Once received, the ElderChoices Plan of Care will be revised accordingly within 10 days of its receipt. If any problems are encountered with implementing the requested revisions, the DAAS RN will contact the personal care provider to discuss possible alternatives. These discussions and the final decision regarding the requested revisions must be documented in the nurse narrative. The final decision, as stated above, rests with the DAAS RN.

214.400 Reporting Personal Care Services Provided to Beneficiaries in the Alternatives For Adults With Physical Disabilities Waiver Program 1-1-13

When an applicant is assessed by the Alternatives for Adults with Physical Disabilities Waiver RN/Counselor, a plan of care is developed. As in other Medicaid waiver programs, this plan of care supersedes any other plan of care that may have been previously developed by another Medicaid provider for the applicant. The Alternatives plan of care must include all waiver and non-waiver services appropriate for the applicant, such as Personal Care. The Alternatives Plan of Care must also include any services reimbursed by payers other than Medicaid.

Providers enrolled in the Medicaid Program to provide any of these non-waiver services and who are providing services to an Alternatives beneficiary, must report these services to the DAAS Waiver RN/Counselor. This information is required, regardless of the payer of services. Information required may include, but is not limited to, plans of care, prescriptions for services, changes in status, etc. If a provider provides **any** service to an individual who is participating in the Alternatives for Adults with Physical Disabilities Waiver Program, he or she must report these services immediately to the DAAS Waiver RN/Counselor in his or her area. Any service billed to Medicaid through a provider's provider identification number may be subject to recoupment if the service is not included on the Alternatives plan of care.

Providers who are unsure about whether an individual is participating in the Alternatives for Adults with Physical Disabilities Waiver Program should contact either the individual or the Alternatives Waiver RN/Counselor.

215.100 Assessment and Service Plan Formats 1-1-13

A. The Division of Medical Services (DMS), in some circumstances and for certain specified providers, requires exclusive use of form DMS-618 (**View or print form DMS-618.**) to satisfy particular Program documentation requirements.

1. Whether Medicaid does or does not require exclusive use of form DMS-618, all documentation required by the Personal Care Program must meet or exceed DMS regulations as stated in this manual and other official communications.

2. When using form DMS-618, attachments may be necessary to complete assessments and service plans and/or to comply with other rules.

   a. An assessing Registered Nurse (RN) must sign or initial and date each attachment he or she adds to a required personal care document.

   b. The authorizing physician must sign (or initial) and date each attachment he or she adds to a service plan or other required document.

B. The Division of Medical Services requires Residential Care Facility (RCF) Personal Care providers to use exclusively form DMS-618 and to comply with all rules applicable to RCFs regarding the use of form DMS-618.

C. For assessments completed on individuals participating in the IndependentChoices Program, the following applies:

For IndependentChoices participants who are also active waiver participants in the ElderChoices Program, the DMS-618 is not required.Only the AR Path assessment will be used by the DAAS RN. The assessment tool used for waiver level of care determination and the waiver plan of care will suffice to support authorization for personal care services, if signed by the DAAS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective the date of the DAAS RN's signature on the waiver assessment tool or the waiver plan of care, whichever is the latter of the two. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver plan of care must include, at least, the information included on the DMS-618 that is utilized to support the

medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in documentation whether or not an extension of benefits is requested. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.

215.330 Service Plan Revisions 1-1-13

NOTE: Subsections (A) (3) and (B) are not applicable to IndependentChoices program.

A. The attending physician must authorize permanent service plan changes before the provider amends service delivery.

1. For purposes of this requirement, a **permanent** service plan change is one expected to last 30 days or more.
2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.
3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.
   a. While changes in the amount, frequency or duration of a service must be documented in the medical record, an increase or a reduction of 10% or less in the average **amount** of service (measured in service time) over a period of fewer than 30 days does not in itself require a service plan revision. If the amount of service remains unchanged, but the frequency or duration of a service is modified, documentation of the reason for the change is required, but no physician authorization is required.
   b. The reasons for the service variances must be written daily in the service documentation.

B. Providers may reduce a beneficiary's services without the physician's prior authorization only by meeting the following conditions:

1. The provider must advise the physician of the reduction in services in writing, within 14 working days following the first day of reduced services.
2. The provider must request the physician's written approval of the reduction.
   a. The provider is responsible for obtaining the physician's signed authorization.
   b. The physician may fax the signed authorization to the provider and maintain the original in the beneficiary's file in the physician's office.

C. The physician must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by the physician.

E. Service plan revisions and updates since the previous assessment must remain with the service plan. Updates since the previous assessment must include documentation of when and why the change occurred.

216.000 Coverage 1-1-13

A. Personal care services, as described in this manual, are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease that are:

1. Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

2. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family".

3. Prior authorized by DMS or its designee when the beneficiary is under the age of 21,

4. Provided by an individual who is

   a. Qualified to provide the services,

   b. Supervised by a registered nurse (RN) or (when applicable) a Qualified Mental Retardation Professional (QMRP) and

   c. Not a member of the beneficiary's family OR

   d. Qualified to provide the service according to approved policy in the IndependentChoices Program.

5. Furnished in the beneficiary's home or, at the State's option, in another location.

B. Medicaid restricts coverage of personal care to services directly helping a beneficiary with certain specified routines and activities, regardless of the beneficiary's ability or inability to execute other non-covered routines and activities.

216.400 Personal Care Aide Service and Documentation Responsibility 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

It is the responsibility of the personal care aide to accomplish the following:

A. Perform authorized tasks as instructed by the supervising RN or QMRP.

B. Maintain a service log.

1. The service log must be completed at the time services are delivered.

2. If the service log is not completed concurrently with service delivery, coverage may be denied.

3. Refer to Sections 220.110 through 220.112 for service log requirements.

C. Provide necessary documentation showing the date, time, nature and scope of authorized services delivered.

D. Provide necessary documentation showing the date, time, nature and scope of emergency services delivered.

1. If an emergency requires the personal care aide to perform a personal care service task not included on the personal care service plan, the personal care aide must receive when possible, prior approval from the supervising registered nurse or QMRP to perform the task.

2. When prior approval is not possible, the personal care aide may perform the emergency service task, but she or he must receive post-service approval from the supervising registered nurse or QMRP.

3. Document the circumstances in detail, describing:

   a. The nature of the emergency,

   b. The action or task required to resolve the emergency and

   c. The justification for the unscheduled service.

E. If a personal care aide does not perform a particular task scheduled on the service plan, the personal care aide must document why she or he did not perform the task that day.

217.120 Duration of Benefit Extension 1-1-13

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 or the physician signs the service plan indicating a CHRONIC CONDITION that will not improve within the next six (6) months, DMS may authorize services 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 being requested.
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.

220.110 Service Log 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

Instructions in this section apply to all beneficiaries' service logs, with one exception. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers maintain their service logs by means of the format and instructions of form DMS-873, *"Arkansas Department of Human Services Division of Medical Services Instructions for completing the Service Log & Aide Notes For Personal Care Services in a Residential Care Facility"*. Effective for dates of service on and after March 1, 2008, form DMS-873 is found in Section V of this manual and DMS requires that RCF Personal Care providers use it exclusively for its designated purposes. See Section 220.111 for special documentation requirements regarding multiple beneficiaries who are attended by one aide. Those instructions at Section 220.111 do not apply to RCF Personal Care providers, effective for dates of service on and after March 1, 2008. See Section 220.112 for special documentation requirements regarding multiple aides attending one beneficiary. Those instructions at Section 220.112 do not apply to RCF Personal Care providers, effective for dates of service on and after March 1, 2008. The examples in these sections and in Section 220.110 are related to food preparation, but personal care beneficiaries may receive other services in congregate settings if their individual assessments support their receiving assistance in that fashion.

A. Medicaid covers only service time that is supported by an aide's service log.

B. Service time in excess of the maximum service time estimates in the authorized service plan is covered only when the provider complies with the rules in Sections 215.330 and 220.110 through 220.112.

C. The time estimate in the service plan is not service documentation. It is an estimate of the anticipated minimum and maximum daily duration of medically necessary personal care aide service for an individual beneficiary.

D. For each service date, for each beneficiary, the personal care aide must record the following:

1. The time of day the aide begins the beneficiary's services.
2. The time of day the aide ends a beneficiary's services. This is the time of day the aide concludes the service delivery, not necessarily the time the aide leaves the beneficiary's service delivery location.
3. Notes regarding the beneficiary's condition as instructed by the service supervisor.
4. Task performance difficulties.

5. The justification for any emergency unscheduled tasks and documentation of the prior-approval or post-approval of the unscheduled tasks.
6. The justification for not performing any scheduled service plan required tasks.
7. Any other observations the aide believes are of note or that should be reported to the supervisor.

E. If the aide discontinues performing service-plan-required tasks at any time before completing all of the required tasks for the day, the aide will record:

1. The beginning time of the non-service-plan-required activities,
2. The ending time of the non-service-plan-required activities,
3. The beginning time of the aide's resumption of service-plan-required activities and
4. The beginning and ending times of any subsequent breaks in service-plan-required aide activities.
5. If the aide discontinues or interrupts the beneficiary's service-plan-required activities at one location to begin service-plan-required activities at another location, the aide must record the beginning and ending times of service at each location.

221.000 Documentation 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

Rule D in this section is effective for dates of service on and after March 1, 2008.

The personal care provider must keep and make available to authorized representatives of the Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and representatives of the Department of Health and Human Services and its authorized agents or officials; records including:

A. If applicable, certification by the Home Health State Survey Agency as a participant in the Title XVIII Program. Agencies that provided Medicaid personal care services before July 1, 1986 are exempt from this requirement.

B. When applicable, copies of pertinent residential care facility license(s) issued by the Office of Long Term Care.

C. Medicaid contract.

D. Effective for dates of service on and after March 1, 2008, RCF Personal Care providers will be required, when requested by DHS, to provide payroll records to validate service plans and service logs.

E. Documents signed by the supervising RN or QMRP, including:

1. The initial and all subsequent assessments.
2. Instructions to the personal care aide regarding:
   a. The tasks the aide is to perform,
   b. The frequency of each task and
   c. The maximum number of hours and minutes per month of aide service authorized by the beneficiary's attending physician.
3. Notes arising from the supervisor's visits to the service delivery location, regarding:
   a. The condition of the beneficiary,
   b. Evaluation of the aide's service performance,
   c. The beneficiary's evaluation of the aide's service performance and

d. Difficulties the aide encounters performing any tasks.

4. The service plan and service plan revisions:

a. The justifications for service plan revisions,

b. Justification for emergency, unscheduled tasks and

c. Documentation of prior or post approval of unscheduled tasks.

F. Any additional or special documentation required to satisfy or to resolve questions arising during, from or out of an investigation or audit. "Additional or special documentation," refers to notes, correspondence, written or transcribed consultations with or by other healthcare professionals (i.e., material in the beneficiary's or provider's records relevant to the beneficiary's personal care services, but not necessarily specifically mentioned in the foregoing requirements). "Additional or special documentation," is not a generic designation for inadvertent omissions from program policy. It does not imply and one should not infer from it that, the State may arbitrarily demand media, material, records or documentation irrelevant or unrelated to Medicaid Program policy as stated in this manual and in official program correspondence.

G. The personal care aide's training records, including:

1. Examination results,

2. Skills test results and

3. Personal care aide certification.

H. The personal care aide's daily service notes for each beneficiary, reflecting:

1. The date of service,

2. The routines performed on that date of service, noted to affirm completion of each task.

3. The time of day the aide began performing the first service-plan-required task for the beneficiary;

4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;

5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks and

6. The time of day the aide completed the last service-plan-required task for the day for that beneficiary.

I. Notes, orders and records reflecting the activities of the physician, the supervising RN or QMRP, the aide and the beneficiary or the beneficiary's representative; as those activities affect delivering personal care services.

222.100 Personal Care Aide Selection, Training and Continuing Education 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

A. The beneficiary must receive Medicaid Personal Care services from a certified personal care aide who is not a member of the beneficiary's family. The Medicaid agency defines, "a member of the beneficiary's family" as:

1. A spouse.

2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent.

3. Legal guardian of the person.

4. Attorney-in-fact granted authority to direct the beneficiary’s care.

B. Personal care aides must be selected on the basis of such factors as:

1. A sympathetic attitude toward the care of the sick,
2. An ability to read, write and carry out directions and
3. Maturity and ability to deal effectively with the demands of the job.

C. The personal care provider is responsible for ensuring that personal care aides in its employ are:

1. Certified as personal care aides,
2. Participate in all required in-service training and
3. Maintain at least "satisfactory" competency evaluations from their supervisors in all personal care tasks they perform.

D. DMS will deem valid the Certified Personal Care Aide status of an individual with

1. Personal Care Aide Certification conferred before April 1, 1998, and
2. Documentation of ongoing compliance with Personal Care Program policies in effect before April 1, 1998, regarding continuing education and competency requirements.
3. The deemed status will be effective for dates of service on and after April 1, 1998, conditional upon the certified aide's continuing compliance with program policies.

E. A qualified training program (see Section 222.110) may waive the training component of personal care aide certification requirements for individuals who can document previous experience as personal care aides, nurse's aides or similar occupations requiring the same skills needed by personal care aides.

1. The qualified training program must verify the individual's previous experience.
2. The individual must pass the personal care aide examinations and skills tests.

F. Certified Nursing Assistants with current valid credentials are deemed qualified personal care aides.

G. Certified Home Health Aides with current valid credentials are deemed qualified personal care aides.

222.110 Conduct of Training 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

A. A personal care aide training program may be offered by any organization meeting the standards in this section for:

1. Instructor qualifications,
2. Content and duration of personal care aide training and
3. Documentation of personal care aide training and certification.

B. Personal Care provider agencies conducting personal care aide training must maintain their training program documentation.

C. Personal Care providers hiring or contracting with individuals or organizations to conduct personal care aide training must maintain the individual's or organization's training program documentation. The provider is responsible for maintaining the training program documentation file.

D. Required training program documentation includes:

1. The number of hours each of classroom instruction and supervised practical training.

2. Names and qualifications of instructors and copies of licenses of supervising registered nurses.
3. Street addresses and physical locations of training sites, including facility names when applicable.
4. Maintaining samples of the forms used to document the beneficiary's consent to the training in their home, if the training includes supervised practical training in the home.
5. The course outline.
6. Lesson plans.
7. The instructor's methods of supervising trainees during practical training.
8. The training program's methods and standards for, determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide.
9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course.
10. The training program's minimum standard for successful completion of the course.
11. Evidence and documentation of successful completions (Certificates supported by internal records).

E. Personal Care providers are responsible for the upkeep of all required training program documentation.

F. A qualified personal care aide training and certification program must include instruction in each of the subject areas listed in Section 222.120.

G. Classroom and supervised practical training must total at least 40 hours.

1. Minimum classroom training time is 24 hours.
2. Minimum time for supervised practical training is 16 hours.
    a. "Supervised practical training" means training in a laboratory or other setting in which:
        (1). The trainee demonstrates knowledge by performing tasks on an individual while
        (2). The trainee is under supervision as defined in Section 220.100.
    b. Trainees must complete at least 16 hours of classroom training before beginning any supervised practical training.
3. Supervised practical training may occur at locations other than the site of the classroom training.
    a. However, trainees must complete at least 24 hours of classroom training before undertaking any supervised practical training at an actual service delivery site.
    b. The training program must have the written consent of the beneficiary or the beneficiary's representative if aide trainees furnish any of the beneficiary's services at the beneficiary's service delivery location.
        (1). A copy of the beneficiary's consent must be maintained in the file of each aide trainee receiving supervised practical training at the beneficiary's service delivery location.
        (2). The beneficiary's daily service documentation must include the names of the supervising RN and the personal care aide trainees.

4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse whose current credentials are on file with the provider.
    a. The qualified registered nurse must possess a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of in-home health care.
    b. Other individuals may provide instruction under the supervision of the qualified registered nurse.
    c. Supervised practical training with a consenting personal care beneficiary for a subject must be personally supervised by:
        (1). The qualified registered nurse or
        (2). By a licensed practical nurse under the general supervision of the qualified registered nurse.

H. Providers must maintain documentation demonstrating that aide training meets the requirements set forth herein.

222.120 Personal Care Aide Training Subject Areas 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

A. Correct conduct toward beneficiaries, including respect for the beneficiary, the beneficiary's privacy and the beneficiary's property.

B. Understanding and following spoken and written instructions.

C. Communications skills, especially the skills needed to:

1. Interact with beneficiaries,
2. Report relevant and required information to supervisors and
3. Report events accurately to public safety personnel and to emergency and medical personnel.

D. Record-keeping, including:

1. The role and importance of record keeping and documentation.
2. Service documentation requirements and procedures, especially all documentation Medicaid requires of personal care aides, as described in Medicaid Personal Care Program policy statements current at the time of the aide's training.
3. Reporting and documenting non-medical observations of beneficiary status.
4. Reporting and documenting, when pertinent, the beneficiary's observations regarding their own status.

E. Recognizing and reporting, to the supervising RN or QRMP, when changes in the beneficiary's condition or status require the aide to perform tasks differently than instructed.

F. State law regarding delegation of nursing tasks to unlicensed personnel.

G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.

H. Safe transfer techniques and ambulation.

I. Normal range of motion and positioning.

J. Recognizing emergencies and knowledge of emergency procedures.

K. Basic household safety and fire prevention.

L. Maintaining a clean, safe and healthy environment.

M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the beneficiary with:

1. Bed bath
2. Sponge, tub or shower bath
3. Shampoo; sink, tub or bed
4. Nail and skin care
5. Oral hygiene
6. Toileting and elimination
7. Shaving
8. Assistance with eating
9. Assistance with dressing
10. Efficient, safe and sanitary meal preparation
11. Dishwashing
12. Basic housekeeping procedures
13. Laundry skills

222.130 Personal Care Aide Certification 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

A. A personal care aide trainee must pass an examination based on the curriculum of the personal care aide training course.

1. Some of the examination may be oral.
2. Examinations must include written questions requiring written answers, in sufficient number for instructors or other qualified training program personnel to determine that trainees meet or surpass a minimum standard for reading and writing.

B. The personal care aide candidate must demonstrate the ability to perform all tasks required of personal care aides, by meeting or exceeding minimum standards in a personal care services skills test.

C. An aide trainee successfully completing training must receive a dated certificate confirming that the individual is a Certified Personal Care Aide qualified for employment in that capacity.

1. The certificate must contain the name of the training entity.
2. The certificate must contain the signature of an individual authorized by the training program to certify the qualifications of personal care aides.

222.140 In-Service Training 1-1-13

NOTE: This section is not applicable to the IndependentChoices program.

Medicaid requires personal care aides to participate in at least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

A. Each in-service training session must be at least 1 hour in length.

1. When appropriate, in-service training may occur at a personal care service delivery location when the aide is furnishing personal care services.

2. In-service training at a service delivery site may occur only if the beneficiary or the beneficiary's representative has given prior written consent for training activities to occur concurrently with the beneficiary's care.

B. The Personal Care Program provider agency and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

244.000 Duration of PA 1-1-13

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 or the physician signs the service plan indicating a CHRONIC CONDITION that will not improve within the next six (6) months.

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.