ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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

DATE: **January 1, 2013**

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

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	7-1-07	201.000	1-1-13
201.100	7-1-07	201.100	1-1-13
__	__	201.105	1-1-13
211.000	7-15-12	211.000	1-1-13
212.000	7-15-09	212.000	1-1-13
212.100	7-1-07	212.100	1-1-13
212.200	7-15-09	212.200	1-1-13
212.300	7-1-11	212.300	1-1-13
212.400	7-15-09	212.400	1-1-13
__	__	213.100	1-1-13
213.110	7-1-07	213.110	1-1-13
__	__	213.111	1-1-13
__	__	213.112	1-1-13
213.120	10-13-03	213.120	1-1-13
213.200	7-15-12	213.200	1-1-13
213.210	7-1-07	213.210	1-1-13
213.220	7-1-07	213.220	1-1-13
213.230	7-1-07	213.230	1-1-13
__	__	213.231	1-1-13
__	__	213.232	1-1-13
213.300	7-15-12	213.300	1-1-13
213.320	7-1-07	213.320	1-1-13
213.330	7-15-09	213.330	1-1-13
213.400	7-15-09	213.400	1-1-13
__	__	213.405	1-1-13
__	__	213.410	1-1-13
__	__	213.420	1-1-13
__	__	213.430	1-1-13

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
__	__	213.440	1-1-13
__	__	213.450	1-1-13
__	__	213.460	1-1-13
__	__	213.470	1-1-13
__	__	213.480	1-1-13
__	__	213.490	1-1-13
214.000	7-1-07	214.000	1-1-13
214.100	7-15-09	214.100	1-1-13
215.000	7-15-09	215.000	1-1-13
215.100	7-15-09	215.100	1-1-13
216.100	7-1-07	216.100	1-1-13
216.200	7-1-07	216.200	1-1-13
216.400	7-1-07	216.400	1-1-13
216.500	7-1-07	216.500	1-1-13
216.510	7-1-07	216.510	1-1-13
219.000	7-15-09	219.000	1-1-13
231.000	10-13-03	231.000	1-1-13
__	__	231.100	1-1-13
241.000	7-1-07	241.000	1-1-13
242.200	7-1-07	242.200	1-1-13
242.201	7-1-07	242.201	1-1-13
242.210	7-1-07	242.210	1-1-13
242.310	7-1-07	242.310	1-1-13
242.311	7-1-07	242.311	1-1-13
__	__	242.312	1-1-13
__	__	242.313	1-1-13
242.320	7-15-09	242.320	1-1-13

Explanation of Updates

Sections 201.000, 201.100, 211.000, 212.000, 212.100, 212.200, 212.300, 212.400, 213.110, 213.120, 213.200, 213.210, 213.220, 213.230, 213.300, 213.320, 213.330, 213.400, 214.000, 214.100, 215.000, 215.100, 219.000, 231.000, 241.000, 242.200, 242.201, 242.210, 242.310, 242.311, and 242.320 are updated to reflect the most current rules and regulations for the Alternatives for Adults with Physical Disabilities (AAPD) Waiver program based on a recent amendment to the AAPD Waiver.

Sections 201.105, 213.100, 213.111, 213.112, 213.231, 213.232, 213.405, 213.410, 213.420, 213.430, 213.440, 213.450, 213.460, 213.470, 213.480, 213.490, 231.100, 242.312, and 242.313 are added to reflect the most current rules and regulations for the Alternatives for Adults with Physical Disabilities (AAPD) waiver program based on a recent amendment to the AAPD Waiver.

Section 216.100 is set to "Reserved" and its content is moved to Section 213.410.

Section 216.200 is set to "Reserved" and its content is moved to Section 213.420.

Section 216.400 is set to "Reserved" and its content is moved to Section 213.450.

Section 216.500 is set to "Reserved" and its content is moved to Section 213.460.

Section 216.510 is set to "Reserved" and its content is moved to Section 213.490.

Revisions to the AAPD provider manual comply with revisions to the waiver amendment approved by CMS effective January 1, 2013. The revisions were made to ensure agreement between the approved waiver document and the provider manual, to clarify policy applicable to waiver services provided through the consumer-direction model, provide further details regarding documentation requirements and primarily to provide policy regarding implementation of the universal assessment process for level of care determinations for this Home and Community-Based Services waiver 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

201.000 Arkansas Medicaid Enrollment Requirements for Alternatives for Adults with Physical Disabilities (Alternatives Waiver) 1-1-13

Alternatives for Adults with Physical Disabilities Waiver Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. **Consumer-Directed Attendant Care**

Consumer-Directed Attendant Care providers must be certified by the Division of Aging and Adult Services (DAAS) as having met all Centers for Medicare and Medicaid Services (CMS)-approved provider criteria for the services to be provided.

DAAS certification of Attendant Care providers is contingent upon participation in the financial management services process as required by federal guidelines for consumer-directed programs. Participation in the financial management services process does not change the procedure for filing claims. Claims are submitted to HP Enterprise Services and are processed by HP Enterprise Services. Prior to payment, the fiscal intermediary deducts appropriate withholdings and processes Medicaid payment to the provider.

NOTE: For a beneficiary to qualify for self-direction, the beneficiary must be able to perform the tasks of an employer (recruit, hire, train, manage and fire his/her attendant care provider), as well as monitor the employee's timesheets and approve payment.

If the beneficiary cannot perform the employer duties, a legal representative (i.e. legal guardian, spouse or attorney-in-fact), may act on the beneficiary's behalf in the role of employer. An attorney-in-fact is a person who has been given the authority by the beneficiary under a power of attorney to direct the beneficiary's care. Directing a beneficiary's care would include recruiting, hiring, training, managing, terminating attendants, monitoring attendant service timesheets and approving payment.

If a beneficiary cannot perform the duties of an employer and does not already have a spouse, legal guardian or attorney-in-fact to direct the beneficiary's care, the beneficiary must receive services through an agency.

During assessment and reassessment, if determined the beneficiary is able to self-direct, the DAAS RN/Counselor will obtain the beneficiary's signature on the verification of ability to self-direct.

B. **Consumer-Directed Agency Attendant Care**

Consumer-Directed Agency Attendant Care providers must be certified by the Division of Aging and Adult Services (DAAS) as having met all CMS-approved provider criteria for the services to be provided.

C. **Traditional Agency Attendant Care**

Traditional Agency Attendant Care providers must be certified by the Division of Aging and Adult Services (DAAS) as having met all CMS-approved provider criteria for the services to be provided.

D. **Environmental Accessibility/Adaptations/Adaptive Equipment**

Environmental Accessibility/Adaptations/Adaptive Equipment providers must be certified by the Division of Aging and Adult Services (DAAS) as having met all CMS-approved provider criteria for the services to be provided.

E. **Case Management/Counseling Support**

Case Management/Counseling Support providers must be certified by the Division of Aging and Adult Services (DAAS) as having met all CMS-approved provider criteria for the services to be provided.

It is the responsibility of all providers of Alternatives Waiver services to maintain current Division of Aging and Adult Services (DAAS) certification to avoid loss of provider eligibility. Required materials must be submitted to the Division of Aging and Adult Services. **View or print the Division of Aging and Adult Services contact information.** Certifications are renewed annually, with the exception of Agency Attendant Care providers, whose certifications are renewed every three years. If required recertification documents are not received by the Division of Aging and Adult Services prior to expiration of the current certificate, action will be taken to close the provider's identification number and Medicaid provider number. Payment cannot be authorized for services provided beyond the certification period.

Once received and it is determined that eligibility requirements are met for certification, DAAS will forward a copy of the DAAS certificate and licensure, if applicable, to HP along with the Medicaid contract and application.

201.100 Providers of Alternatives for Adults with Physical Disabilities Waiver Services in Arkansas and Bordering States 1-1-13

Providers of Alternatives for Adults with Physical Disabilities Waiver services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet all Arkansas Medicaid participation requirements outlined in the Medicaid provider manual.

A routine services provider may be enrolled in the program as a provider of routine Alternatives services to eligible Arkansas Medicaid beneficiaries. Reimbursement may be available for all Attendant Care Services, Environmental Accessibility Adaptation/Adaptive Equipment Services, and Case Management Services covered in the Arkansas Medicaid Program. Claims must be filed according to instructions in this manual.

201.105 Provider Assurances 1-1-13

A. Agency Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted an Alternatives Waiver Plan of Care.

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers and Counseling Support Managers must be trained prior to providing services to an AAPD beneficiary.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.

3. Staff are required to attend orientation training prior to allowing the employee to deliver any Alternatives Waiver service(s). This orientation shall include, but not be limited to, a:
   a. Description of the purpose and philosophy of the Alternatives Waiver Program;
   b. Discussion and distribution of the provider agency's written code of ethics;
   c. Discussion of activities which shall and shall not be performed by the employee;
   d. Discussion, including instructions, regarding Alternatives Waiver record keeping requirements;
   e. Discussion of the importance of the Plan of Care;
   f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
   g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality:
   h. Proper completion of all forms, including the Attendant Care Provider Certification/Medicaid application

B. Code of Ethics (Agency and Consumer-Directed Services)

The Provider agrees to follow and/or enforce for each employee providing services to an Alternatives Waiver beneficiary a written code of ethics that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized individuals are to accompany the employee to beneficiary's residence;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
7. No smoking in the beneficiary's residence;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

211.000 Scope 1-1-13

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 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) intermediate level of care. The beneficiary'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. 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.

212.000 Eligibility for Alternatives for Adults with Physical Disabilities 1-1-13

A. To qualify for the Alternatives for Adults with Physical Disabilities Program, an individual must meet the targeted population as described in this manual, and must be found to require a nursing facility intermediate level of care. Individuals meeting the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the AAPD Waiver Program.

B. The beneficiary intake and assessment process for the Alternatives Program includes a determination of categorical eligibility, a nursing facility level of care determination, the development of a Plan of Care, and the beneficiary's notification of his or her choice between home and community-based services and institutional services.

C. Candidates for participation in the program (or their representatives) must make application for services at the DHS office in the county of their residence. Medicaid eligibility is determined by the DHS County Office and 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.

D. 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. Medical assessment results in a score of three or more on Cognitive Performance Scale; or
3. Medical assessment results in a Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) score of three or more.

E. 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 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.

F. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Alternatives for Adults with Physical Disabilities 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.

G. The Alternatives for Adults with Physical Disabilities waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated beneficiaries who can be served in any waiver year. Once maximum number of unduplicated beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:

1. Each Alternatives application will be accepted and medical and financial eligibility will be determined.
2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled, and that the applicant is number X in line for an available slot.
3. Entry to the waiver will then be prioritized based on the following criteria:
    a. Waiver application determination date for persons inadvertently omitted from the waiver waiting due to administrative error;
    b. Waiver application determination date for persons being discharged from a nursing facility after a 90-day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer:
    c. Waiver application determination date for persons in the custody or DHS Adult Protective Services (APS)
    d. Waiver application determination date for all other persons.

212.100 Level of Care Determination 1-1-13

A prospective Alternatives beneficiary must require a nursing facility intermediate level of care. Registered Nurses and Rehabilitation Counselors employed by the Division of Aging and Adult Services (DAAS RN/Counselors) perform a comprehensive assessment of each applicant to determine his or her personal assistance and health care needs. The assessment tool is ArPath, the electronic interRAI home care instrument, which evaluates the candidate's level of care need.

The intermediate level of care determination is made by medical staff with the Department of Human Services, Office of Long Term Care. The determination is based on the comprehensive assessment performed by a DAAS RN/Counselor, using standard criteria for functional disability in evaluating an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving Alternatives services.

Reevaluations will be performed annually by the DHS medical staff to determine the beneficiary's continuing need for an intermediate level of care. The DAAS RN/Counselor performs a comprehensive assessment periodically (at least annually), and the Office of Long Term Care re-determines level of care annually. The results of the level of care determination and the reevaluation are documented on form DCO-704,Decision for Nursing Home Placement.

NOTE: While federal guidelines require level of care reassessment at least annually, DAAS may reassess a beneficiary's level of care and/or need any time it is deemed appropriate by the DAAS RN/Counselor to ensure that a beneficiary is appropriately placed in the Alternatives Program and is receiving services suitable to his or her needs.

212.200 Plan of Care 1-1-13

A. Each beneficiary in the Alternatives program must have an individualized Alternatives Plan of Care (AAS-9503). The authority to develop an Alternatives Plan of Care is given to the Medicaid State agency's designee, the Division of Aging and Adult Services RN/Counselor. At the discretion of the beneficiary, the Alternatives Plan of Care is developed with the Alternatives beneficiary, a representative or the beneficiary's family, or anyone requested by the beneficiary.

B. When developing the waiver Plan of Care, the beneficiary may freely choose a family member or individual to appoint as Decision Making Partner. The beneficiary, Decision Making Partner and/or legal representative may participate in all decisions regarding the types, amount and frequency of services included in the Plan of Care. The Decision Making Partner or legal representative may participate in choosing the provider(s) for the beneficiary. If anyone other than the beneficiary chooses the provider, the DAAS RN/Counselor will identify that individual on the Plan of Care.

C. The Alternatives Plan of Care developed by the DAAS RN/Counselor includes, but is not limited to, the following:

1. Beneficiary identification and contact information to include full name and address, phone number, date of birth, Medicaid number and the effective date of Alternatives waiver eligibility.
2. Primary and secondary diagnosis.
3. Contact person.
4. Physician's name and address.
5. The amount, frequency and duration of Alternatives waiver services and the name of the service provider chosen by the beneficiary, Decision Making Partner or legal representative to provide the services.
6. Other services outside the Alternatives services, regardless of payment source, identified and/or ordered to meet the beneficiary's needs.
7. The election of community services by the waiver beneficiary or beneficiary's Decision Making Partner or legal representative; and
8. The name and title of the DAAS RN/Counselor responsible for the development of the beneficiary's Plan of Care.

D. If waiver eligibility is approved by the DHS county office, a copy of the Plan of Care signed by the DAAS RN/Counselor, and the waiver beneficiary, Decision Making Partner or legal representative, will be forwarded to the beneficiary or representative and the certified Medicaid service provider(s) included on the Plan of Care.. The service provider and the Alternatives beneficiary must review and follow the signed authorized Plan of Care. Services cannot begin until the Medicaid provider receives the authorized Plan of Care from the DAAS Rehab Counselor or RN. The original Plan of Care will be maintained by the DAAS RN/Counselor.

E. The implementation of the Plan of Care by a provider must ensure that services are:

1. Individualized to the beneficiary's unique circumstances;
2. Provided in the least restrictive environment possible;
3. Developed within a process assuring participation of those concerned with the beneficiary's welfare;
4. Monitored and adjusted as needed, based on changes authorized and reported by the DAAS/RN Counselor regarding the waiver Plan of Care;
5. Provided within a system that safeguards the beneficiary's rights to quality services as authorized on the waiver Plan of Care; and

6. Documented carefully, with assurance that required information is recorded and maintained.

NOTE: Each service included on the Alternatives Plan of Care must be justified by the DAAS RN/Counselor. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary, and other factors deemed appropriate by the DAAS RN/Counselor.

Each Alternatives service must be provided according to the beneficiary Plan of Care. Providers may bill only for services in the amount and frequency that is authorized in the Plan of Care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

REVISIONS TO A BENEFICIARY PLAN OF CARE MAY ONLY BE MADE BY THE DAAS RN/COUNSELOR.

NOTE: All revisions to the Plan of Care must be authorized by the DAAS RN/Counselor. A revised Plan of Care will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on an Alternatives Plan of Care, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the Alternatives Plan of Care are subject to recoupment.

212.300 Temporary Absences from the Home 1-1-13

Once an Alternatives eligibility application has been approved, waiver services must be provided in order for eligibility to continue. Unless stated otherwise below, the county Department of Human Services (DHS) office must be notified immediately by the DAAS RN/Counselor when waiver services are discontinued, and action will be initiated by the DHS county office to close the waiver case. Providers will be notified by the DAAS RN/Counselor.

A. Absence from the Home – Institutionalization

An individual cannot receive waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e. hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the beneficiary is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver beneficiary is admitted to a hospital, the DHS county office will not take action to close the waiver case, unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the DAAS RN/Counselor will notify the DHS county office and action will be initiated by the DHS county office to close the waiver case.

2. If the DHS county office becomes aware that a beneficiary has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of admission, but the Medicaid case will be left open. When the beneficiary returns home, the waiver case may be reopened effective the date the beneficiary returns home. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the beneficiary's admission to the facility.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Payment for attendant care services may be allowed for the date of a beneficiary's admission to an inpatient facility if the provider can provide verification that services were provided before the beneficiary was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- **Copies of claim forms or timesheets listing the times that attendant care was provided**
- **A statement from the inpatient facility showing the time that the beneficiary was admitted**

This information must be submitted to DAAS within 10 working days of receiving a request for verification.

If providers are unable to provide proof that attendant care services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. Attendant care services provided on the same day the beneficiary is discharged from the inpatient facility are billable when provided according to policy and after the beneficiary was discharged.

B. Absence due to Reasons Other than Institutionalization

When a waiver beneficiary is absent from the home for reasons other than institutionalization, the DHS county office will not be notified unless the beneficiary does not return home within 30 days. If, after 30 days, the beneficiary has not returned home and the providers can no longer deliver services as prescribed by the Plan of Care (e.g., the beneficiary has left the state and the return date is unknown), the DAAS RN/Counselor will notify the DHS county office. Action will be taken by the DHS county office to close the waiver case.

C. Providers Accompanying Clients during Absences from the Home

In cases where the beneficiary is absent from the home for reasons other than institutionalization, such as a vacation or attending college, and the beneficiary asks the provider to accompany him/her and to continue providing services, authorization from the DAAS/RN Counselor is required. If Medicaid reimbursement will be requested upon their return to the home, prior to arrangements being finalized, authorization from the DAAS RN/Counselor must be secured by the CSM. As this decision will be discussed with DAAS and DMS staff, the request must be submitted to the DAAS RN/Counselor at least 2 weeks prior to the date of travel. The request must include the travel destination, means of travel, how long the beneficiary will be absent from the home, and the purpose of the trip. Each case will be handled individually, taking into account the beneficiary's status, medical condition and the circumstances of the absence.

The CSM must report via the AAS-9511 and/or e-mail any instances where the beneficiary will be absent from the home for any length of time, and the provider is with them.

NOTE: It is the responsibility of the provider to notify the DAAS RN/Counselor immediately via form AAS-9511 upon learning of a change in the beneficiary's status.

212.400 Reporting Changes in Participant's Status 1-1-13

Because the provider has more frequent contact with the beneficiary, many times the provider becomes aware of changes in the beneficiary's status sooner than the DAAS RN/Counselor, Counseling Support Manager, or DHS County Office. It is the provider's responsibility to report these changes immediately so proper action can be taken. Providers must complete the Waiver

Provider Communication-Change of Client Status Form (AAS-9511) and send it to the DAAS RN/Counselor. A copy must be retained in the provider's beneficiary case record. Regardless of whether or not the change may result in action by the DHS county office, providers must immediately report all changes in the beneficiary's status to the CSM.

The Counseling Support Manager (case manager/CSM) is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for reassessment if necessary and reporting any beneficiary complaints and changes in status to the DAAS RN/Counselor, or Nurse Manager, immediately upon learning of the change.

213.100 Environmental Accessibility Adaptations/Adaptive Equipment 1-1-13

Environmental Accessibility Adaptations/Adaptive Equipment services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment are physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, to function with greater independence in the home, and preclude or postpone institutionalization. Adaptive equipment also enables the Alternatives beneficiary to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise, and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

If adaptations are made to rental property, it is the responsibility of the beneficiary and the CSM to obtain written permission from the property owner prior to the DAAS RN/Counselor implementing the adaptation on the Plan of Care. In addition, the beneficiary must have a current 12-month lease for the rented property.

213.110 Benefit Limit - Environmental Accessibility Adaptations/Adaptive Equipment 1-1-13

The overall cap for Environmental Accessibility Adaptations/Adaptive Equipment is $7,500 per the lifetime of the eligible Alternatives waiver beneficiary. If a waiver beneficiary is receiving Environmental Accessibility Adaptations and Adaptive Equipment, the combined cost cannot exceed the $7,500 overall cap. A waiver beneficiary may access through the waiver several occurrences of Environmental Accessibility Adaptations or for several items of Adaptive Equipment over a span of years, or he/she may access the whole $7,500 at one time. Once the $7,500 per eligible beneficiary is reached, no further Environmental Accessibility Adaptations/Adaptive Equipment can be accessed through the waiver by the eligible waiver beneficiary during his/her remaining lifetime.

213.111 Examples of Acceptable Environmental Accessibility Adaptations/Adaptive Equipment 1-1-13

Acceptable environmental accessibility adaptations/adaptive equipment must be necessary for the welfare of the Alternatives beneficiary and may include, but are not limited to:

- Installing and/or repairing ramps and grab-bars
- Widening doorways
- Modifying bathroom facilities

- Installing specialized electronic and plumbing systems
- Installing an electrical entry door to the home – if based on need and accessibility
- Replacing the motor on a wheelchair lift
- Installing overhead tracks for transferring
- Installing hand controls for a vehicle owned by the beneficiary
- Installing a van/automobile lift
- Durable Medical Equipment not payable by Medicare/Medicaid
- Generators for ventilator-dependent beneficiaries

213.112 Examples of Unacceptable Environmental Accessibility Adaptations/Adaptive Equipment 1-1-13

Unacceptable environmental accessibility adaptations/adaptive equipment to the home include, but are not limited to:

- Those that are of general utility
- Those not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.
- Those that add to the total square footage of the home
- Purchase of any vehicle, such as automobile/van, regardless of previously installed modifications or adaptations
    - Policy prohibits the purchase of a vehicle. Prior to authorizing vehicle modifications, verification must be provided showing the beneficiary owns, or is purchasing, the vehicle for which modifications are requested. This must be verified by viewing the title or the financial contract between the beneficiary and the title holder.
- Replacement of all carpeting when door widening is completed
- Repairs or updates necessary in order to complete the environment accessibility adaptations/adaptive equipment

    Examples:

    - In order to install a ramp, repairs to the porch or deck must be made to support the ramp. The ramp could be approved; the repairs to the existing porch or deck could not be approved.
    - Bathroom needs adaptation to install a new commode for disabled individual. In order to replace the commode, the flooring must be replaced due to dry rot or decay. The new commode could be approved. The sub-flooring, etc., could not be approved.

213.120 Provider Qualifications Environmental Accessibility Adaptations/Adaptive Equipment 1-1-13

Individuals seeking certification by the Division of Aging and Adult Services and enrollment as Medicaid providers of Alternatives environmental accessibility adaptations/adaptive equipment services must meet the following criteria:

A. The provider of services must be a builder, tradesman or contractor.

B. The provider must be licensed (where applicable) as appropriate for home improvement contracting or adaptation and equipment provided.

C. The provider must certify that his or her work meets state and local building codes.

D. The provider must be knowledgeable of and comply with, the Americans with Disabilities Act Accessibility Guidelines.

E. Contractors are required to adhere to the Uniform Federal Accessibility Standards.

NOTE: All environmental modifications requiring electrical or plumbing work must be completed by a licensed professional. If a contractor subcontracts with an electrician or plumber, verification of the subcontractor's license will be requested.

213.200 Consumer-Directed Attendant Care Service 1-1-13

Consumer-Directed Attendant Care service is assistance to a medically stable AAPD beneficiary in accomplishing tasks of daily living that the beneficiary is unable to complete independently. Assistance may vary from actually doing a task for the beneficiary, to assisting the beneficiary to perform the task or providing safety support while the beneficiary 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. Consumer-Directed Attendant Care services may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care services, accompanying a beneficiary to assist with shopping, errands, etc.

NOTE: For a beneficiary to qualify for self-direction, the beneficiary must be able to perform the tasks of an employer (recruit, hire, train, manage and fire his/her attendant care provider), as well as monitor the employee's timesheets and approve payment.

If the beneficiary cannot perform the employer duties, a legal representative (i.e., legal guardian, spouse or attorney-in-fact) may act on the beneficiary's behalf in the role of employer. An attorney-in-fact is a person who has been given the authority by the beneficiary under a power of attorney to direct the beneficiary's care by recruiting, hiring, training, managing, terminating attendants, monitoring attendant service timesheets and approving payment.

If a beneficiary cannot perform the duties of an employer and does not already have a spouse, legal guardian or attorney-in-fact to perform those duties, the beneficiary must receive services through an agency.

During assessment and reassessment, if determined the beneficiary is able to self-direct, the DAAS RN/Counselor will obtain the beneficiary's signature on the verification of ability to self-direct.

A. If the beneficiary is deemed appropriate for consumer-directed services and Attendant Care service is selected, a consumer-directed approach will be used in the provision of Attendant Care services. The beneficiary or representative is free to select the tasks within the Plan of Care to be performed and when these tasks will be accomplished. Each beneficiary or representative who elects to receive Consumer-Directed Attendant Care services must agree to and be capable of recruiting, hiring, training, managing and terminating attendants. The beneficiary or representative must also monitor Consumer-

Directed Attendant Care service timesheets and approve payment to the attendant for services provided by signing the timesheets.

Beneficiaries or representatives who can comprehend the rights and accept the responsibilities of consumer-directed care may wish to have Alternatives Consumer-Directed Attendant Care services included on their Plan of Care.

NOTE: Policy applicable to the consumer-direction model requires action by the beneficiary or their representative in the direction of their care. If the beneficiary is capable of meeting the requirements of consumer-direction, but allows a Decision Making Partner to assist them in making decisions, the Decision Making Partner does not have to meet the definition of a legal representative. However, if the beneficiary is not capable of meeting the requirements of consumer-direction, the representative directing the beneficiary's care must meet the definition of a legal representative, as explained in this manual.

B. The ArPath comprehensive assessment completed by the DAAS RN/Counselor for each Alternatives Waiver applicant will contain information relative to the beneficiary's functional, social and environmental situation.

C The beneficiary's CSM will assist the beneficiary or his/her legal representative in fulfilling the responsibilities of employing an attendant care provider, including understanding the minimum qualifications set forth in this manual for provider certification and the Medicaid enrollment and reimbursement process. During the initial assessment and prior to waiver approval, the beneficiary will be instructed to notify the DAAS RN/Counselor when an attendant has been recruited and a formal service agreement between the beneficiary and the attendant, form AAS-9512, Self-Directed Attendant Care Service Agreement, has been completed and signed. Instructions are provided with the Attendant Care packet. Once approved for the waiver, this process is the responsibility of the Counseling Support Manager (CSM).

To avoid a delay in or absence of services, the beneficiary is encouraged to choose an agency attendant care provider to work pending the intended employee's certification and Medicaid application process. It is also recommended that the beneficiary maintain the services of an agency provider for purposes of back-up, in the event the employed attendant is unable to work due to illness or vacation or resigns or is terminated from employment.

D When the AAS-9512, Attendant Care Service Agreement, is finalized between the beneficiary and the attendant, the attendant will apply for DAAS certification and Medicaid provider enrollment. The provider applicant is not authorized to begin AAPD services before being approved as a Medicaid provider and receiving from the RN/Counselor a current copy of the beneficiary's Plan of Care. As an enrolled Medicaid provider, the attendant will be responsible for all applicable Medicaid participation requirements, including maintaining current certification and claims submission.

Service agreements and required tax documents do not transfer from one waiver beneficiary 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.

213.210 Tasks Related to Attendant Care Services 1-1-13

Tasks related to Attendant Care services may include one or more of the following:

- Feeding Assistance

- Encourage Fluids
- Grooming/Oral Care
- Bathing
- Shampoo
- Mobility/Transfer Assistance
- Shave
- Supervise/Assist with Ambulation
- Skin Care
- Range of Motion Exercise
- Toileting

Catheter Care: To be in compliance with the Nurse Practice Act, ONLY a family member who has been trained by a medical professional to perform catheter care procedures is allowed to perform catheter care. Therefore, ONLY Attendant Care aides who are family members, and who have been trained by a medical professional, are allowed to provide catheter care.

Medication Assistance: To be in compliance with the Nurse Practice Act, a family member is allowed to perform medication assistance. A non-related Attendant Care Aide is allowed to perform medication assistance ONLY if:

- The Alternatives beneficiary is mentally capable of understanding what medications he or she is taking, and
- The Alternatives beneficiary is mentally capable of understanding the purpose of taking the medication and when the medication must be taken, and
- The Alternatives beneficiary's physical limitations prevent him or her from getting the medication out of its container and getting it into his or her mouth.

If the Alternatives beneficiary is mentally capable, based on the above, and can tell the non-related Attendant Care Aide the following three things, the non-related Attendant Care Aide is allowed to dispense medication to the Alternatives beneficiary:

- The Alternatives beneficiary can tell the non-related Attendant Care Aide that it is time to take his or her medication, and
- The Alternatives beneficiary can tell the non-related Attendant Care Aide to open the medication bottle and get out the required amount of medication, and
- The Alternatives beneficiary can tell the non-related Attendant Care Aide to put the medication in his or her mouth.

Meal Preparation: Meal preparation is hands-on assistance with tasks involved in preparing and serving a meal and cleaning articles and utensils used in the meal preparation. Meal preparation is allowed ONLY for the Alternatives beneficiary. Meal preparation is not allowed for other members of the household. If the beneficiary lives in a house with other household members, meal preparation for the other members of the household is not allowed as part of the Alternatives waiver services.

Housekeeping: Incidental housekeeping means cleaning of the floor and furniture ONLY in the room, space or location occupied by the Alternatives beneficiary; for example, the beneficiary's bedroom. Incidental housekeeping is hands-on assistance with waiver-covered tasks that the

beneficiary cannot physically perform himself or herself. This does not mean cleaning the whole house. If the beneficiary lives in a house with other household members, housework for the other members of the household is not allowed as part of the Alternatives waiver services.

Laundry: Incidental laundry means washing items incidental to the care of the beneficiary. It is hands-on assistance with covered laundry tasks such as laundering the beneficiary's clothing, bed linens and towels that the beneficiary cannot physically perform himself or herself. This does not mean washing for the whole household. If the beneficiary lives in a house with other household members, washing laundry for the other members of the household is not allowed as part of the Alternatives waiver services.

Shopping/Errands/Transportation: Incidental shopping means shopping for the beneficiary or assisting the beneficiary with his or her shopping needs. It is hands-on assistance with covered tasks the beneficiary cannot physically perform himself or herself. This does not include shopping for the whole household if there are other household members. If the beneficiary lives in a house with other household members, shopping for the other household members is not allowed as part of the Alternatives waiver services.

Errands means performing tasks outside of the beneficiary's home for the beneficiary, such as picking up prescriptions at the pharmacy. This does not mean running errands for the whole household if there are other household members. If the beneficiary lives in a house with other household members, running errands for the other household members is not allowed as part of the Alternatives waiver services.

Transportation through the Alternatives waiver is non-medical transportation and is for the benefit of the beneficiary in his or her activities in accessing the community, such as transporting the beneficiary to the grocery store, transporting the beneficiary to activities like bingo, transporting the beneficiary to visit friends or community centers. This does not include transportation for the whole household if there are other household members. If the beneficiary lives with other household members, transporting the other household members is not allowed as part of the Alternatives waiver services.

Transportation to and from doctors' appointments is to be handled through the Arkansas Medicaid Transportation Program.

213.220 Benefit Limit Consumer-Directed Attendant Care 1-1-13

One unit of consumer-directed attendant care service equals a full 15 minutes. The established benefit limit for Alternatives Attendant Care Service is 11,648 units per state fiscal year. Services are reimbursable when provided according to the beneficiary's approved Plan of Care.

A maximum of 8 hours per day, 7 days per week is allowed. The number of hours included on a beneficiary's Plan of Care is based on a medical assessment, the individual's needs and other support systems in place.

213.230 Provider Qualifications Consumer-Directed Attendant Care Services 1-1-13

Provider qualifications for Consumer-Directed Attendant Care are as follows:

A. The Attendant Care provider shall not be an individual who is legally responsible for the beneficiary, i.e., spouse or legal guardian or attorney-in-fact authorized to direct the beneficiary's medical and service needs.

B. The Attendant Care provider shall not be an individual chosen by the beneficiary as his/her Decision-Making Partner.

C. The Attendant Care provider must be 18 years of age or older.

D. The Attendant Care provider must be a United States citizen or legal immigrant authorized to work in the U.S.

E. The provider of Attendant Care Services must be free from evidence of the following:

1. Abuse or fraud in any setting
2. Violations in the care of a dependent population
3. Conviction of a crime related to a dependent population
4. Conviction of a violent crime

F. The Attendant Care provider must be able to read and write at a level sufficient to follow written instructions and maintain records.*

G. The Attendant Care provider must be able to do simple math in order to complete the Alternatives Attendant Care Provider Claim Form (AAS-9559).

H. The Attendant Care provider must be in adequate physical health to perform the job tasks required.

I. The Attendant Care provider must be free from diseases transmittable through casual contact.

J. The Attendant Care provider must agree to a criminal history background check.

K. The Attendant Care Provider shall not be a state employee unless provided a written waiver of § 19-11-705, which refers to employee conflict of interest, by the director of the Department of Finance and Administration granting permission to proceed with the transaction to such extent and upon such terms and conditions as may be specified. Such waiver and permission may be granted when the interests of the state so require or when the ethical conflict is insubstantial or remote.

NOTE: If an Attendant Care provider cannot read, write or do simple math, he/she must provide written documentation and give the name, address and telephone number of the person who will read to him/her any written instructions, who will complete and maintain accurate records for him/her and who will complete billing claim forms for him/her. This arrangement does not remove or alter any contractual agreement between the provider and the Arkansas Medicaid Program or the Division of Aging and Adult Services.

213.231 Attendant Address Changes 1-1-13

If an attendant plans to change address, he/she must notify the Division of Aging and Adult Services in writing prior to the move via form "Authorization for Change of Address", which can be found at the DAAS website (**http://www.daas.ar.gov/**). **View or print the AAPD Attendant Care Manual**. If this form is not submitted timely, Medicaid reimbursement may be delayed. Change in address MUST BE IN WRITING.

The change of address information for the attendant care provider shall not be included on the bottom of claim form (AAS-9559) mailed to HP. The ONLY way a new address change can be made is to follow the instructions above.

The CSM should assist the beneficiary in reporting all attendant care provider address changes to the DAAS RN/Counselor via the Change of Beneficiary Status (AAS-9511).

213.232 Attendant Care Provider Name Change 1-1-13

If a provider's name has changed for any reason (such as in marriage or divorce), the attendant care provider must get a new Social Security card. If the name on the payment and Social

Security information does not match, the Internal Revenue Service may suspend the money from the attendant care provider's claims. If the name on the Social Security card is not correct, the attendant should contact the Social Security office in the county where they live. Social Security will assist the attendant in making the correction. Once the correct Social Security card is received, the attendant should send a copy to DAAS.

The CSM should assist the beneficiary in reporting all attendant care provider name changes to the DAAS RN/Counselor via the AAS-9511.

213.300 Agency Attendant Care 1-1-13

Agency Attendant Care service is assistance to a medically stable AAPD beneficiary in accomplishing tasks of daily living that the beneficiary is unable to complete independently. The services are performed by an Attendant Care employee hired by an agency selected by the waiver beneficiary. 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 Service may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care Services while accompanying a beneficiary to assist with shopping, errands, etc.

If Agency Attendant Care Service is selected, beneficiaries 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 beneficiary chooses to have Attendant Care Service provided through an agency, the beneficiary may choose one of two agency Attendant Care Service options: 1) beneficiary/co-employer where the beneficiary 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 Service where the agency performs both the managing of the Attendant Care employee and hiring and fiscal responsibilities.

A. If the beneficiary chooses the beneficiary/co-employer (managing employer) option, the beneficiary 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 beneficiary may also recruit prospective Attendant Care Aides who are then referred to the agency for consideration for hiring. The agency chosen by the beneficiary to provide Attendant Care Service is the employer of beneficiary-selected/recruited staff and performs necessary payroll and human resources functions.

   If the beneficiary chooses the traditional agency model option, the agency performs both the responsibilities of managing the Attendant Care employee and the hiring and fiscal responsibilities. Beneficiaries who decide to have their Attendant Care services provided through an agency may wish to have Alternatives Agency Attendant Care Service included on their Plan of Care.

   In either case, the agency must ensure that the Attendant meets the following criteria:

   1. The Attendant Care provider shall not be an individual who is legally responsible for the beneficiary, i.e., spouse or legal guardian or attorney-in-fact authorized to direct the beneficiaries medical and service needs.
   2. The Attendant Care provider shall not be an individual chosen by the beneficiary as his/her Decision-Making Partner.
   3. The Attendant Care provider must be 18 years of age or older.

4. The Attendant Care provider must be a United States citizen or legal immigrant authorized to work in the U.S.

5. The provider of Attendant Care Services must be free from evidence of the following:

   a. Abuse or fraud in any setting

   b. Violations in the care of a dependent population

   c. Conviction of a crime related to a dependent population

   d. Conviction of a violent crime

6. The Attendant Care provider must be able to read and write at a level sufficient to follow written instructions and maintain records.

7. The Attendant Care provider must be free from diseases transmittable through casual contact.

8. The Attendant Care Provider shall not be a state employee unless provided a written waiver of § 19-11-705, which refers to employee conflict of interest, by the director of the Department of Finance and Administration granting permission to proceed with the transaction to such extent and upon such terms and conditions as may be specified. Such waiver and permission may be granted when the interests of the state so require or when the ethical conflict is insubstantial or remote.

B. The comprehensive assessment completed by the DAAS RN/Counselor for each Alternatives Waiver applicant contains information relative to the beneficiary's functional, social and environmental situation.

C. The Attendant Care agency must staff and notify the DAAS RN/Counselor via the AAS-9510, according to established program policy, when an Attendant has been assigned to a waiver beneficiary. In addition, prior to Medicaid reimbursement, an agency must enter into an Alternatives Attendant Care Service Agreement, AAS-9512, signed by the agency representative and the waiver beneficiary. This agreement must be sent to the DAAS Central Office prior to claims submission.

D. The Attendant Care agency will review the weekly time sheets of each Alternatives attendant in its employ to ensure that time sheets are accurate and have been signed by the beneficiary or other responsible party.

E. The Attendant Care agency will visit each Alternatives beneficiary's home at least once every ninety days to evaluate beneficiary satisfaction and attendant performance.

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

213.320 Benefit Limit – Agency Attendant Care 1-1-13

One unit of agency Attendant Care services equals a full 15 minutes. The established benefit limit for Alternatives Agency Attendant Care Services is 11,648 units per state fiscal year. Services are reimbursable when provided according to the beneficiary's approved Plan of Care.

NOTE: The benefit limit established per SFY for Attendant Care services includes Attendant Care, Agency Attendant Care, or a combination of the two. The maximum of 8 hours per day, 7 days per week also includes Attendant Care, Agency Attendant Care, or a combination of the two.

213.330 Provider Qualifications Agency Attendant Care 1-1-13

Class A or Class B Home Health Agencies licensed by the Arkansas Department of Health to provide personal care and enrolled in the Arkansas Medicaid Program as a personal care provider may apply to enroll as a Medicaid Alternatives Agency Attendant Care provider. (**www.daas.ar.gov**)

Private Care agencies licensed by the Arkansas Department of Health to provide personal care and enrolled in the Arkansas Medicaid Program as a personal care provider may apply to enroll as a Medicaid Alternatives Agency Attendant Care provider. (**www.daas.ar.gov**)

Agency Attendant Care providers assure that attendants are qualified by education and/or experience to perform Alternatives services, are properly trained and in compliance with all applicable licensure requirements, possess the necessary skills to perform the specific services required to meet the needs of the beneficiary, are bonded to protect the beneficiary from loss due to misconduct or mismanagement of the beneficiary's affairs, and are covered under liability insurance.

213.400 Counseling Support Management (CSM) Services 1-1-13

CSMs must routinely monitor beneficiary's needs and circumstances. This consists of maintaining regular contact, either face-to-face or telephone, with beneficiaries and reporting their status and any changes to the DAAS RN/Counselor immediately.

The responsibilities of the providers of counseling support management services include, but are not limited to:

- Orientation to the concept of consumer-direction. This includes:
  - Explaining Alternatives for Adults with Physical Disabilities (AAPD) program policy to beneficiary
  - Providing skill training on how to recruit, interview, hire, evaluate, manage, or dismiss Attendant Care provider
  - Assisting with completion, and distribution to designated parties, of all necessary federal and state forms required for beneficiary to be employer
  - Assisting the beneficiary's hire choice(s) for Attendant Care provider in applying for and maintaining DAAS certification and Medicaid provider enrollment
  - Assisting beneficiary in training Attendant Care provider/employee
  - Training beneficiary and Attendant Care provider in proper billing procedures, completion of all required forms, and maintenance of required documentation.
- Monitor beneficiary's needs, employer status and circumstances
  - Maintain regular contact, face-to-face and telephone, with beneficiary
  - Monitor beneficiary compliance with AAPD program policy
  - Monitor other services (waiver and non-waiver) provided to AAPD beneficiary for compliance with plan of care and appropriateness of service and reporting concerns to DAAS RN/Counselor
  - Reporting when participation in consumer-direction model is no longer appropriate to the DAAS RN/Counselor
  - Document beneficiary's condition, condition of home, living environment, overall success of beneficiary/attendant care provider arrangement during home visits
  - Measure beneficiary's progress toward Plan of Care goals

- Assess beneficiary's personal emergency preparedness plan, including risk factors, and what to do in an emergency
- Report beneficiary status and any changes in beneficiary condition, need, or circumstances to DAAS RN/Counselor immediately
- Monitor beneficiary maintenance of required documentation such as Plan of Care, timesheets, and copies of Attendant Care Claim Form DHS-9559 (for claims not submitted electronically)
- Provide management reports to DAAS

- Assess beneficiary's service needs and refer to resources
  - Assess beneficiary's service needs to assist in accessing services that currently may or may not be in place (This does not refer to a medical assessment nor replace any eligibility requirements for any Medicaid program)
  - Schedule appointments related to gaining access to medical, social, educational, and other services appropriate to beneficiary's needs (includes, but is not limited to, medical appointments, transportation services, and appointments with DHS)
  - Refer beneficiary for community resources such as energy assistance, legal assistance, or emergency housing
  - Assist beneficiary in completing applications for assistance; conference with others, on behalf of, to assist in application process for services
  - Assist beneficiary in accessing environmental modifications/adaptive equipment service according to established procedures provided by DAAS and/or DMS

  NOTE: If the CSM is an employee of a provider type 84 that is submitting a bid to provide a waiver service, the CSM may not assist the waiver beneficiary in securing the other two required bids.

  - Assist beneficiary in accessing alternate funding sources if beneficiary has exhausted the $7500 lifetime benefit for environmental modifications/adaptive equipment service, and has a need for further modifications/equipment

- Provide counseling support to beneficiary
  - Provide support to the extent the beneficiary needs assistance
  - If well-being of beneficiary is compromised due to poor choices by beneficiary, work to resolve in a manner respectful of beneficiary's independence and integrity
  - Contact DAAS RN/Counselor to report any difficulties beneficiary is having with consumer direction and request assistance from DAAS if needed
  - Report to DAAS RN/Counselor if beneficiary, in the CSM's professional judgment, is not appropriate for consumer-direction

- Attend training as provided or required by DAAS

213.405 Counseling Support Management Instructions for Environmental Accessibility Adaptations/Adaptive Equipment 1-1-13

A. The DAAS RN/counselor will send the waiver Plan of Care to all providers and the CSM for all beneficiaries with pending environmental accessibility adaptations/adaptive equipment.

1. Claim forms for environmental accessibility adaptations/adaptive equipment may be sent to the CSM along with the Plan of Care.
2. The Plan of Care must describe the type of environmental accessibility adaptations/adaptive equipment needed, and be as clear and specific as possible.
3. For environmental accessibility adaptations/adaptive equipment not included on the existing Plan of Care, the CSM must contact the DAAS RN/counselor.

B. The CSM is responsible for securing bids for the environmental accessibility adaptations/adaptive equipment service. Once bids are secured, the CSM will accept, deny or ask for additional information.

1. Three bids must be obtained.
   a. If three bids cannot be obtained, the CSM supervisor must approve the submission of two bids.
   b. In these cases, justification for why three bids could not be obtained must be documented in the beneficiary's record.
2. Providers must know what type of environmental accessibility adaptations/adaptive equipment they are to provide before going to the home.
3. The CSM should schedule and meet with each provider in the beneficiary's home to go over the environmental accessibility adaptations/adaptive equipment recommendations listed in the Plan of Care.
4. The Property Owner's Consent for Home Modifications form must be completed and signed by the home's owner if the beneficiary does not own the home to be modified.
   a. It must also be verified that the beneficiary has a 12-month lease with the property owner.
   b. A copy of the lease agreement completed by the homeowner and beneficiary must also be included.
5. The CSM must obtain proof of vehicle ownership for environmental accessibility adaptations/adaptive equipment to vehicles. A copy of a vehicle title will suffice.
   a. Payments may be authorized for modifications to vehicles owned by a beneficiary's parent or spouse when the beneficiary depends on the parent or spouse for transportation.

C. The CSM will send the following to his or her supervisor:

1. All Bids
2. Copy of the beneficiary's Plan of Care with a very specific description of the type of job to be completed
3. Property Owner's Consent for Environmental Accessibility Adaptations/Adaptive Equipment form
4. Lease agreement
5. Proof of vehicle ownership

D. The CSM's supervisor will review and approve bids. Once a bid is approved, the CSM's supervisor will initial and date the approved bid, and send it to the CSM.

E. Within five working days of receiving the information from their supervisor, the CSM will send a copy of the approved bid to the beneficiary and to the environmental accessibility adaptations/adaptive equipment provider so that the provider can begin the project.

F. The contractor/provider will have 45 days from the date of notification of approval to begin work.

G. Within five working days of being notified that the project is complete, the CSM or CSM's supervisor must conduct final inspection of the environmental accessibility adaptations/adaptive equipment.

1. The CSM will complete the Client Satisfaction Statement and obtain the beneficiary's signatures and other information requested.

a. The CSM will complete the claim form and obtain the beneficiary and provider's signatures.

b. The CSM will send the completed and signed claim form to the DAAS Central office, PO Box 1437, Slot S530, Little Rock, AR, 72203-1437, Attn: Alternatives.

H. The CSM will file the following in the beneficiary's record for audit purposes, and send a copy to the DAAS RN/counselor:

1. All bids for the project

2. Satisfaction Statement

2. Approval letter

4. Copy of claim form

NOTE: Neither CSMs nor CSM supervisors are liable for payment of approved bids.

213.410 CSM Assessment/Service Plan Development 1-1-13

This component is an annual face-to-face contact by the CSM with the waiver beneficiary and contact with other professionals, caregivers or other parties on behalf of the beneficiary. Assessment is performed for the purpose of collecting information about the beneficiary's situation and functioning and to determine and identify the beneficiary's problems and needs.

This component includes activities that focus on needs identification. Activities, at a minimum, include:

A. The assessment of the beneficiary to determine the need for any medical, educational, social and other services. Specific assessment activities include:

1. Taking beneficiary history

2. Identifying the needs of the beneficiary

3. Completing related documentation

4. Gathering information from other sources, such as family members, medical providers and educators, if necessary, to form a complete assessment of the beneficiary

B. An assessment may be completed between annual assessments, if the CSM deems it necessary.

1. Documentation in the beneficiary's case file must support the assessment, such as life-changing diagnoses, major changes in circumstances, death of a spouse, change in primary caregiver, etc.

2. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support this activity.

C. Service plan development builds on the information collected through the assessment phase and includes ensuring the active participation of the beneficiary. The goals and actions in the care plan must address medical, social, educational and other services needed by the beneficiary. Service plans must:

1. Be specific and explain each service needed by the beneficiary.

2. Include all services, regardless of payment source.

3. Include support services available to the beneficiary from family, community, church or other support systems and what needs are met by these resources.

4. Identify immediate, short term and long term ongoing needs as well as how these needs/goals will be met.

5. Assess the beneficiary's individualized need for services and identify each service to be provided along with goals.

D. The assessment and the service plan may be accomplished at the same time, during the same visit, or separately.

213.420 Service Management/Referral and Linkage 1-1-13

This component includes activities by the CSM that help link waiver beneficiaries with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered counseling support management.

This component details functions and processes that include contacting service providers selected by the beneficiary and negotiation for the delivery of services identified in the service plan. Contacts with the beneficiary and/or professionals, caregivers or other parties on behalf of the beneficiary may be a part of service management.

213.430 CSM Monitoring 1-1-13

Counseling support managers must maintain contact with beneficiaries as frequently as needed, but at least once a month to help determine whether services are being furnished according to the beneficiary's Plan of Care; the adequacy of the services in the Plan of Care; and changes in the beneficiary's needs or status. CSMs must give beneficiaries their office phone numbers, and leave a business card or contact sheet in the beneficiary's home in case of concerns or questions.

CSMs must initially meet with the beneficiary face-to-face within 10 working days of receiving the AAPD waiver Plan of Care from the DAAS RN/Counselor to discuss the beneficiary's needs and find out who is currently providing any or all of their services. This includes beneficiaries new to the program and beneficiaries transferring from one county to another. Following the initial home visit, CSMs must make unannounced face-to-face monitoring visits once a month for the first three months. If the beneficiary's circumstances are not stable or if there have been changes in providers during the previous 3 months, monthly visits must continue. Once the beneficiary's circumstances are stable, no attendant care provider changes are made and no problems noted, unannounced face-to-face monitoring visits may be reduced to once every 3 months. As long as the CSM believes, in their professional judgment, that the beneficiary's circumstances are not stable or have not been stable for at least 3 months, monthly visits must continue. During months a face-to-face visit is not required, a telephone contact is required. The CSM must speak to the beneficiary unless a legal representative has been identified.

A CSM Monitoring Form must be completed for all face-to-face monitoring contacts. A contact is not considered a face-to-face "monitoring contact" unless the required monitoring form is completed, dated and signed by the CSM and filed in the beneficiary's record. Documentation in the narrative of the beneficiary's record will suffice for telephone contacts rather than completing the actual monitoring form. All face-to-face and telephone contacts must be documented in the beneficiary's case file for review and audit purposes. During each home visit, the CSM must document the beneficiary's condition, the condition of the home, living environment, attendant's duties and overall success of the beneficiary/attendant arrangement. The CSM must view the

beneficiary's copy of the current AAPD plan of care and Medicaid claims submitted for self-directed Attendant Care services. For claims filed electronically, CSMs must review the documentation the provider used to complete electronic claims, which most often will be a copy of the Attendant Care Claim Form or similar documentation. Any problems, changes, complaints, observations, concerns or other beneficiary issues (e.g. attendant care changes, problems, information regarding change of condition, hospital admissions, hospital discharges, address changes, telephone number changes, deaths, any change in waiver or nonwaiver services) must be documented in the beneficiary's record and reported immediately to the DAAS RN/counselor via the Change of Beneficiary Status form (AAS-9511) or e-mail. Copies of required forms and/or communication must be maintained in the beneficiary's record.

CSMs review the Plan of Care with the beneficiary during all face-to-face visits to ensure that services are being provided according to the plan and required documentation is available for review. The CSM must also measure the beneficiary's progress toward Plan of Care goals. It is the CSM's responsibility to report to the DAAS RN/Counselor if, in their professional judgment, the individual is not appropriate for consumer-direction. At that time, action will be taken to secure Agency Attendant Care for the participant.

NOTE: EXCEPTIONS TO "UNANNOUNCED" HOME VISITS

While the purpose of unannounced visits is primarily directed towards ensuring the beneficiary's health and welfare, it is not intended to be less than reasonable and productive. Therefore, please consider the following when planning for home visits to beneficiaries, IF "unannounced" has not proven successful:

- Is the beneficiary's residence in an extremely rural area and more than 30 miles from the CSMs office?
- Has at least one attempt been made for an unannounced visit with no success?
- If the answer to those questions above are "yes," please:
    - Contact the beneficiary and schedule a week or a range of several days that you will be in the area for a home visit.
    - Verify the beneficiary and attendant (or provider) will be available during that period of time. (It is still preferred to avoid giving a specific day.)
    - Conduct the home visit during the time period scheduled with the beneficiary.

Face-to-face home visits are required and must be completed. If the beneficiary fails to cooperate in meeting with the CSM, the DAAS RN/Counselor must be notified and appropriate action will be taken, which may include closure of the case.

213.440 Change in Attendant Provider 1-1-13

The CSM must notify the DAAS RN/Counselor immediately via form AAS-9511 when an attendant is no longer working. This change should be reported on an attendant change form.

The CSM should assist the beneficiary's hire choice in completing the provider application packet and sending it to DAAS.

The CSM will document who is no longer working and if the beneficiary has another individual ready to hire. A Changing or Adding an Attendant form must be completed and copies mailed to the DHS RN/counselor. This form should be used for agency attendant care as well.

The CSM will send a copy of the Changing or Adding an Attendant form to DAAS central office and to the RN/counselor. It is very important for the client or representative to report the attendant care provider's last day worked on the attendant change form and mail it to the DHS

RN/counselor. DAAS central office will lock the Alternatives provider out of the MMIS upon receipt of the form to preclude unauthorized billing.

It is important that the last date of service reported is correct. It cannot be changed at a later date.

Consider the following when completing the Changing or Adding an Attendant form:

- The form must be complete.
- It should list the client's current providers, as well as the attendant that is no longer working or the attendant that is being added.
- The person completing the form must either type or write his or her name and the date on the form.
- The attendant no longer working MUST have a termination date. Please obtain that date from the client or client's representative. Explain to the client or client's representative that it is very important to keep up with the time worked for each agency and attendant, especially their last day worked, which must be accurate.
- CSMs must understand the importance of giving the correct last day worked on an attendant because it affects the attendant's pay.
- Also, if the change involves an agency, be specific by noting the complete agency name and location. Report if an agency is replacing a provider or if the client is adding the agency as an additional provider.

The Alternatives provider cannot remain an active provider without a client. Once the Alternatives provider closes, the only way they can become active again is to re-enroll as a provider by filling out the required application and tax packet. CSMs should not leave application packets with the clients for attendants to complete. The CSM should assist the attendant in completing the packet to ensure that it is completed correctly and completed by the correct person.

213.450 Support of Financial Management Services 1-1-13

Counseling support management providers also support the work of the contracted fiscal intermediary by completing with the beneficiary and distributing to the designated party all necessary Federal and State forms required for the beneficiary to be an employer and by completing with the beneficiary and his/her attendant all necessary forms for hiring a new attendant. This includes assisting in compliance with program policy regarding fiscal intermediary services.

213.460 Counseling Support 1-1-13

Consumer-direction offers greater choice and control over all aspects of service provision including the hiring of an attendant, defining the attendant's duties and deciding when and how specific tasks or services are performed. Beneficiaries in the Alternatives waiver program are afforded as much independence and autonomy as possible in deciding the types, amounts and sources of Attendant Care services, Environmental Modifications/Adaptive Equipment services and other support services they receive at the time the waiver plan of care is developed. Counseling Support Management must be available to the extent the beneficiary desires. If the well-being of a beneficiary is compromised because of poor choices made by the beneficiary, the counseling support management provider will work to resolve those situations in a manner respectful of the independence and integrity of the beneficiary. DAAS is available to assist in resolving these issues. This counseling support is crucial to the success of the beneficiary and is covered extensively in training prior to any Counseling Support Manager being assigned an APD beneficiary.

213.470 Requirements for the Tickler System 1-1-13

Each Counseling Support Manager (CSM) must maintain a tickler system for tracking purposes.

A. The tickler system must track and notify the CSM of the following activities:

1. Each active beneficiary in the CSM's caseload
2. Date CSM services began
3. Expiration date of any Medicaid waiver Plan of Care applicable to a given beneficiary
4. Medicaid eligibility date and waiver eligibility date
5. The beneficiary's case reevaluation date, as established by DHS, Division of County Operations
6. Name, address and telephone number of each attendant or agency providing Attendant Care services to waiver beneficiary
7. The certification expiration dates of beneficiary's employees

It is the responsibility of the CSM to maintain a tickler system as described above for those beneficiaries in their specific caseload. However, the record keeping requirements and documentation requirements must be maintained in the beneficiary's file.

213.480 Provider Qualifications Case Management/Counseling Support Management 1-1-13

Entities seeking certification by the Division of Aging and Adult Services (DAAS) and enrollment as Medicaid providers of Alternatives Case Management/Counseling Support Management services must meet the following criteria:

A. The provider must be an agency having demonstrated at least one year of experience providing case management services to individuals age 21 and older with physical disabilities.

B. The provider agency must employ qualified case managers who shall be licensed in the state of Arkansas as a Social Worker, Registered Nurse or Licensed Practical Nurse, or have a bachelor's degree from an accredited institution, or have performed satisfactorily for a period of two years providing case management services to adults with physical disabilities.

C. The agency must have an administrative capacity to ensure quality of services in accordance with state and federal regulations

D. The agency must have the financial management capacity and system that provides documentation of services and costs

E. The agency must have the capacity to document and maintain individual case records in accordance with state and federal regulations.

F. A counseling support manager (CSM) employed by the agency to provide Alternatives counseling support management services must receive training provided by DAAS and/or the certified CSM provider prior to providing services to the Alternatives beneficiary.

213.490 Benefit Limit – Case Management/Counseling Support 1-1-13

One unit of Case Management/Counseling Support equals one month of service. The established benefit limit for Alternatives Case Management is twelve (12) months per SFY. Services are reimbursable when provided according to the beneficiary's approved Plan of Care and according to established Medicaid and DAAS policy. All required components, tasks,

services and support described in this manual and provided to case management providers either in writing or verbally through DMS and/or DAAS training classes are a part of the overall monthly CM/CS service. The monthly service varies depending on the needs of the waiver beneficiary.

214.000 Counseling Support Management Documentation in Beneficiary Files 1-1-13

Documentation in the beneficiary's case file must support all activities provided by the CSM provider for which Medicaid is billed.

The Counseling Support Manager (CSM) must develop and maintain sufficient written documentation to support each service for which billing is submitted. Written description of services provided must emphasize how the goals and objectives of the service plan are being met or are not being met. All entries in a beneficiary's file must be signed and dated by the CSM who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file. Providers' failure to maintain sufficient documentation to support their billing practices may result in recoupment of Medicaid payment. Documentation must consist of, at a minimum, material that includes:

- The beneficiary's name and Medicaid number
- A copy of the waiver beneficiary's AAPD Plan of Care
- A description of the beneficiary's participation in consumer-direction of attendant care services, if applicable
- A brief description of the specific services rendered
- The type of service rendered: assessment, service management and/or monitoring
- The type of contact: face to face or telephone
- The date and actual clock time for the service rendered, including the start time and stop time for each service
- The name of the person providing the service. The CSM providing the service must initial each entry in the case file. If the process is automated and all records are computerized, no signature is required. However, there must be an agreement or process in place showing the responsible party for each entry.
- The place of service (where the service took place: e.g. office, home)
- Updates describing the nature and extent of the referral for services delivered
- Description of how case management and other in-home services are meeting beneficiary's needs
- Progress notes on beneficiary's conditions, whether deteriorating or improving and the reasons for the change; CSMs must notify the DAAS RN/Counselor via form AAS-9511 of any change in a beneficiary's condition.
- Process for tracking the date the beneficiary is due for reevaluation by the Division of County Operations. The tracking is to avoid a beneficiary's case from being closed unnecessarily

Documentation, as described above, is required each time a case management or counseling function is provided.

NOTE: Documentation must be specific and descriptive as it relates to the individual beneficiary. While checklists may be used, information must be

sufficient in supporting the beneficiary was indeed contacted, whether by phone or by a home visit. Providers must make every effort to avoid duplicative documentation that cannot be linked to the specific beneficiary and his/her circumstances.

214.100 Retention of Records 1-1-13

Providers must maintain all records regarding the participation of the beneficiary and the provider in the Arkansas Medicaid Program for a period of six (6) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. The records must be made available to authorized representatives of the Arkansas Division of Medical Services, the Arkansas Division of Aging and Adult Services, the state Medicaid Fraud Control Unit, representatives of the Department of Human Services and its authorized agents or officials.

All documentation must be made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business, except for services provided under the consumer-directed model. Required documentation, as described in this manual, for consumer-directed services may be maintained at the beneficiary's home or the Attendant Care provider's home. It is the responsibility of the beneficiary and the provider to provide requested information for audit purposes. If an audit determines that recoupment is necessary, there will be only thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted at a later date.

215.000 Record Keeping Requirements (Consumer Directed Services Excluded) 1-1-13

DHS requires retention of all records for six (6) years. All medical records shall be completed promptly, filed and retained for a minimum of six (6) years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish records upon request may result in sanctions being imposed.

A. The provider must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with any Medicaid beneficiary.

B. Providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.

C. The provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.

D. Providers must adhere to all applicable professional standards of care and conduct.

E. The provider must make available to the Division of Medical Services, its contractors and designees, the state Medicaid Fraud Control Unit, Program Integrity, representatives of the Center for Medicare & Medicaid Services (CMS) and its authorized agents or officials, all records related to any Medicaid beneficiary.

1. All documentation must be available at the provider's place of business.
2. When records are stored off-premise or are in active use, the provider may certify in writing that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

3. If an audit determines that recoupment is necessary, there will be no more than thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted.

215.100 Record Keeping Requirements for Consumer-Directed Services 1-1-13

DHS requires retention of all records for six (6) years from the date the attendant care service was provided, or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer.

A. The Consumer-Directed Attendant Care provider must maintain sufficient written documentation to support the Alternatives attendant care service for which billing is submitted to Medicaid for reimbursement. As the definition of Attendant Care Services is a bundled service that may include several different tasks as directed by the beneficiary on any given day, the signature of the beneficiary on the DHS-9559 supports that the service was provided based on the waiver Plan of care and was sufficient and satisfactory. No daily log or additional documentation is required to support the provision of Attendant Care Services under the consumer-directed model.

NOTE: For Consumer-Directed Attendant Care providers submitting paper claims to HP for processing, the claim form will be maintained by HP for audit purposes. Maintaining a copy of the claim form in the beneficiary's home or the Attendant Care provider's home is not required. For Attendant Care providers submitting claims to HP through other means (electronically), it is the provider and beneficiary's responsibility to maintain at least one copy of the DHS-9559 for audit purposes. The copy may be at the beneficiary's residence or the provider's residence.

Regardless of the billing method chosen, every billing claim form MUST be signed by both the Attendant Care provider AND the beneficiary.

Maintaining a copy of the waiver plan of care in the beneficiary's home is required, regardless of the claims submission process chosen.

B. Failure to maintain sufficient documentation to support billing practices may result in recoupment of Medicaid payment made to the provider.

C. All written documentation must be made available to authorized representatives of DAAS, the Division of Medical Services (DMS), the state Medicaid Fraud Control Unit, Program Integrity, representatives of the Center for Medicare & Medicaid Services (CMS) and its authorized agents or officials, if requested.

216.100 Reserved 1-1-13

216.200 Reserved 1-1-13

216.400 Reserved 1-1-13

216.500 Reserved 1-1-13

216.510 Reserved 1-1-13

219.000 Beneficiary Appeal Process 1-1-13

When Alternatives for Adults with Physical Disabilities Waiver services are denied, the beneficiary may request a fair hearing from the Department of Human Services according to Sections 191.000 – 191.006 of the Arkansas Medicaid Provider Manuals.

Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. **View or print DHS Appeals and Hearings Section contact information.**

231.000 Method of Reimbursement 1-1-13

The reimbursement rates will be according to the lesser of the billed amount or the Title XIX (Medicaid) maximum for each service. Each provider hired by an AAPD waiver beneficiary to provide self-directed Attendant Care must accept payment as electronic fund transfer or via prepaid credit card. Electronic Funds Transfer (EFT) or prepaid credit card allows providers to have their Medicaid payments automatically deposited instead of receiving a check.

231.100 Counseling Support Management Reimbursement 1-1-13

As stated earlier in this manual, one unit of CSM equals one month of service. To determine if reimbursement is allowable, the CSM agency may bill on a new beneficiary as soon as they receive the beneficiary and begin CSM services. However, for an existing active beneficiary who transfers to an agency, regardless of the time of the month the transfer occurs, the CSM is allowed to start billing the month following the month in which they received the beneficiary and begin CSM services. For example, if a beneficiary is with a CSM provider but wants to change to another CSM agency starting on 3-15-13, the first CSM provider may bill for the month of March and the new CSM receiving the transferred case may start billing for April, if services have begun.

241.000 Introduction to Billing 1-1-13

Alternatives providers of Agency Attendant Care and Case Management/Counseling Support Management services may bill the Arkansas Medicaid Program either on paper or electronically utilizing the CMS-1500 form for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Alternatives providers of Environmental Accessibility Adaptations/Adaptive Equipment may bill the Arkansas Medicaid Program on paper only utilizing the CMS-1500 form for services provided to eligible Medicaid beneficiaries, as the CMS-1500 claim form must be approved by the DAAS RN/Counselor before submission to the HP Enterprise Services Claims Department. Each claim may contain charges for only one beneficiary.

Alternatives providers of Attendant Care Services may bill the Arkansas Medicaid Program either on paper or electronically utilizing the AAS-9559 (Alternatives Attendant Care Provider Claim Form) for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claims submission.

242.200 Alternatives Consumer-Directed Attendant Care Provider Claim Form (AAS-9559) Billing Instructions 1-1-13

HP Enterprise Services offers Attendant Care providers several options for electronic billing. Attendant Care Service providers may submit claims electronically or on paper.

To bill for Consumer-Directed Attendant Care Services, use the Alternatives Attendant Care Provider Claim Form (AAS-9559). **View a sample Alternatives Attendant Care Provider Claim Form (Form AAS-9559.)** The AAS-9559 billing claim forms may be obtained from the Alternatives beneficiary or the Alternatives Counselor or RN. An AAS-9559 billing claim form must be completed and submitted to the HP Enterprise Services Claims Department in order for payment to be received.

242.201 Completion of Alternatives Attendant Care Provider Claim Form AAS-9559 1-1-13

Only original AAS-9559 claim forms are acceptable. Xerox copies will not be accepted.

If a billing claim form is completed properly and mailed within the specified time, payment should be received within two weeks. If the claim form is filled out incorrectly, the form will be returned to the provider, and payment will be delayed. The payroll schedule for the Alternatives waiver program is every other Friday.

The Attendant Care provider and the waiver beneficiary must sign and date the AAS-9559 claim form. If both signatures are not included, the claim form will be returned and payment will be delayed. Original signatures only are accepted on the billing claim form. Do not fax AAS-9559 claim forms to the Alternatives Office or to HP Enterprise Services. The AAS-9559 claim form must be mailed to:

HP Enterprise Services
DAAS Claims
P O Box 709
Little Rock, AR 72203

242.210 Billing Instructions for Agency and Consumer-Directed Attendant Care Providers 1-1-13

The following instructions must be read and carefully followed so that HP Enterprise Services can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Regardless of the date that Attendant Care services begin for an Alternatives beneficiary, Medicaid reimbursement is not allowed prior to the effective date of the Medicaid Provider Identification Number (PIN) as issued by the Medicaid fiscal agent, HP Enterprise Services.

NOTE: It is very important to submit a completed provider certification packet immediately. Each packet must include all of the required documents, tax forms and copies of identification as required for the individual service. Packets received and processed will establish a provider's eligibility as stated in this manual. Provider eligibility will not begin prior to the first day of the month that a correctly completed DAAS certification/Medicaid Attendant Care provider enrollment packet is received by DAAS. Therefore, packets must not be held and mailed in for processing at a later date.

For example, the waiver eligibility effective date for the Alternatives beneficiary is 1-15-07. The Attendant Care provider and the Alternatives beneficiary signed the Alternatives Attendant Care Service Agreement (AAS-9512) on 1-20-07. A correctly completed DAAS certification/Medicaid Attendant Care provider enrollment packet was received by DAAS on 2-10-07. Services provided on or after 2-1-07 will be eligible for reimbursement.

- The Attendant Care Service Agreement (AAS-9512) cannot be back dated.
- Once signed and dated by the provider and the waiver beneficiary, the Attendant Care Service Agreement (AAS-9512) must be postmarked within 14 calendar days of the signatures on the agreement.
- Prior to providing attendant care services, the provider must be certified by DAAS, possess an active Medicaid PIN issued on behalf of the Arkansas Medicaid Program and have a copy of the employer/beneficiary's current Plan of Care provided by the DAAS Rehab Counselor or RN.

Medicaid may be billed only for the amount of services authorized in the Alternatives Plan of Care and only for what the Attendant Care provider has actually provided. MEDICAID CANNOT BE BILLED FOR FUTURE DATES OF SERVICE.

Following is the address and telephone number for the HP Enterprise Services Provider Enrollment Unit in the event there are questions about a PIN number:

HP Enterprise Services
Provider Enrollment Unit
PO Box 8105
Little Rock, AR 72203-8105
(501) 376-2211 or 1-800-457-4454

Following is the address and telephone number for the HP Enterprise Services Provider Assistance Center in the event there are questions about a claim:

HP Enterprise Services
Provider Assistance Center
PO Box 8036
Little Rock, AR 72203-8036
(501) 376-2211 or 1-800-457-4454

If an Attendant Care provider quits working for an Alternatives beneficiary, the DAAS RN/Counselor must be notified immediately in writing, citing the last day of employment.

242.310 Attendant Care Services 1-1-13

Claims for Attendant Care Services must be filed in 15 minute units with a daily maximum of 32 units.

Attendant Care Services may be billed either electronically or on paper. Refer to Section III of this manual for information on electronic billing.

242.311 Consumer-Directed Attendant Care Services 1-1-13

When filing paper claims for Consumer-Directed Attendant Care, Form AAS-9559 must be used. Billing will be monitored to ensure compliance with the waiver Plan of Care. All billing will be reviewed based on the number of units authorized per week, Sunday through Saturday. When computing units, the provider must bill no more than the number of units authorized per week beginning on Sunday. All reviews are conducted based on the number of units billed Sunday through Saturday each week. Units billed outside this timeframe and over the number of authorized units are subject to recoupment.

Regardless of the number of waiver beneficiaries for whom an Attendant Care provider works, no more than 12 hours per day are eligible for reimbursement consideration by the Arkansas Medicaid program. In addition, if an Attendant Care provider is employed by another waiver beneficiary OR another employer, all hours of employment will be considered when authorizing

Attendant Care services for a waiver beneficiary. No more than a total of 12 hours/day including ALL employment, will be allowed for an Attendant Care provider.

Regardless of the number of providers a waiver beneficiary hires, no more hours than authorized on the waiver Plan of Care are eligible for reimbursement consideration by the Arkansas Medicaid Program.

242.312 Signatures on AAS-9559 1-1-13

The beneficiary or legal representative must sign and date the claim form. If the beneficiary is unable to sign, he or she may make an "X" and a Decision Making Partner may write "beneficiary's mark," followed by their name and relationship to the beneficiary. If the beneficiary is unable to make a mark, a legal representative may sign the beneficiary's name then write "by" and his or her name and relationship to the beneficiary. If the claim form is not correctly signed, it will be returned to the attendant care provider, and payment will be delayed.

The Attendant Care provider is not allowed to sign for the beneficiary, regardless of the circumstances.

242.313 Agency Attendant Care Services 1-1-13

Agencies billing for Attendant Care Services may not span a date of service when Agency Attendant Care was not provided. Under no circumstances may spanning include more than one week, Sunday through Saturday. Attendant Care Services billing is monitored for compliance with plans of care and billings are compared to the number of hours authorized per week, Sunday through Saturday.

242.320 Environmental Modifications/Adaptive Equipment 1-1-13

Prior to payment for this service, the waiver beneficiary is required to secure 3 separate itemized bids for the same service. The bids are reviewed by the DAAS RN/Counselor or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the waiver beneficiary, and DAAS RN/Counselor, or designee. A statement of satisfaction form must be signed by the waiver beneficiary prior to any claim being submitted.