ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Cheryl Freeman E-mail cheryl.freeman@dhs.arkansas.gov Phone 501-537-1675

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: CNM 1-16; HomeHealth 2-16; Nursepra 3-16; Prosthet 3-16

Intended Effective Date (Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other July 1, 2017 (Must be more than 10 days after filing date.)

	Date
Legal Notice Published	04/12/2017
Final Date for Public Comment	05/11/2017
Reviewed by Legislative Council	06/16/2017
Adopted by State Agency	07/01/2017

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Thomas Herndon (Contact Person) thomas.herndon@dhs.arkansas.gov (E-mail Address) _____ (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Dawn Stehle/TP·H
Signature

(501) 683-4997 (Phone Number) dawn.stehle@dhs.arkansas.gov (E-mail Address)

Director
Title

6/20/17
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

publication of said notice. _____

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). _____

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. _____

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE 501.537.2064 **FAX** 501.682.3889 **EMAIL:** Brian.jones@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Home Health-2-16, Prosthet-3-16, CNM-1-16, Nursprea-3-16

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   _____

   (b) The reason for adoption of the more costly rule;

   _____

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   _____

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

   _____

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		Next Fiscal Year	
General Revenue	$ 0	General Revenue	$ 0
Federal Funds	$ 0	Federal Funds	$ 0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0	Total	$ 0

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

---

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ $ 0

Next Fiscal Year
$ $ 0

---

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
  (a) justifies the agency's need for the proposed rule; and
  (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
  (a) the rule is achieving the statutory objectives;
  (b) the benefits of the rule continue to justify its costs; and
  (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – Home Health

EFFECTIVE DATE: July 1, 2017

SUBJECT: Provider Manual Update Transmittal HOMEHLTH-2-16

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
203.000	6-1-04	203.000	7-1-17
206.000	11-1-09	206.000	7-1-17
211.100	10-13-03	211.100	7-1-17
211.200	11-1-06	211.200	7-1-17
211.300	10-13-03	211.300	7-1-17
212.150	10-13-03	212.150	7-1-17
217.000	6-1-04	217.000	7-1-17
242.430	10-13-03	242.430	7-1-17

Explanation of Updates

Section 203.000 is updated to reflect that referrals must be renewed every 60 days.

Section 206.000 is updated with current documentation requirements for Home Health providers.

Section 211.100 is updated to reflect that a patient's plan of care must be reviewed no less often than every 60 days.

Section 211.200 is updated with current program criteria for home health services.

Section 211.300 is updated with the current policy describing a Home Health place of service.

Section 212.150 is updated to reflect that a beneficiary may qualify for home intravenous therapy after a face-to-face encounter with a physician or allowed non-physician practitioner.

Section 217.000 is updated to reflect that a registered nurse must visit the beneficiary at least once every 60 days.

Section 242.430 is updated to add the definitions of medical supplies, equipment and appliances.

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

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.

Dawn Stehle /TAH

Dawn Stehle
Director

TOC not required

203.000 Home Health and the Primary Care Physician (PCP) Case Management Program (ConnectCare) 7-1-17

A. Home health care requires a PCP referral except in the following circumstances:

1. Medicaid does not require Medicare beneficiaries to enroll with PCPs; therefore, a PCP referral is not required for home health services for Medicare/Medicaid dual-eligibles.
2. Obstetrician/gynecologists may authorize and direct medically-necessary home health care for postpartum complications without obtaining a PCP referral.

B. A PCP may refer a beneficiary to a specific home health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.

1. PCPs, authorized attending physicians and home health agencies must maintain all required PCP referral documentation in the beneficiary's clinical records.
2. PCP referrals must be renewed when specified by the PCP or every 60 days, whichever period is shorter.

C. PCP referral is not required to revise a plan of care during a period covered by a current referral, but the agency must forward copies of the signed and dated assessment and the revision to the PCP.

206.000 Documentation of Services 7-1-17

Home Health providers must maintain the following records for patients of all ages; see Section 218.000 for additional documentation guidelines regarding physical therapy for patients under the age of 21. Additional information regarding documentation of services is located in Section 140.000 of this manual.

A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans when applicable.

B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.

C. Signed and dated documentation of pro re nata (PRN) visits, which must include the following:

1. The medical justification for each such unscheduled visit.
2. The patient's vital signs and symptoms.
3. The observations of and measures taken by agency staff and reported to the physician.
4. The physician's comments, observations and instructions.

D. Verification, by means of physician or approved non-physician practitioner documentation, that there was a face-to-face encounter with the beneficiary that meets the following requirements:

1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or within 30 days after the start of services.
2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.

3. The face-to-face encounter may be conducted by one of the following practitioners:
   a. The primary care physician.
   b. A nurse practitioner working in collaboration with the primary care physician.
   c. A certified nurse midwife by the scope of practice.
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid physician policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.
   e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.
4. The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that face-to-face to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician ordering the services must:
   a. Document the face-to-face encounter, which is related to the primary reason the patient requires home health services, occurred within the required timeframes prior to the start of home health services.
   b. Must indicate the practitioner who conducted the encounter and the date of the encounter.
6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies or appliances to the extent that a face-to-face encounter requirement would qualify as a durable medical equipment (DME) claim under the Medicare program unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in (D) 3 of this section with the exception of the nurse midwives.

F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications, in each patient's medical records.

G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.

H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.

I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

211.100 Plan of Care Review 7-1-17

A. All home health services are at the direction of the patient's PCP or authorized attending physician.

B. The physician, in consultation with the patient and professional staff, is responsible for establishing the plan of care, specifying the type(s), frequency and duration of services.

C. Medicaid requires the PCP or authorized attending physician to review the patient's plan of care as often as necessary to address changes in the patient's condition, but no less often than every 60 days.

1. The physician establishes the start date of each new, renewed or revised plan of care. A "renewed" plan of care is a plan of care that has been reviewed in accordance with the 60-day requirement and has been authorized by the PCP or authorized attending physician to continue, either with or without revision. A "revised" plan of care is a plan of care developed in response to a change in the patient's condition that necessitates prompt review by the physician and reassessment by the case nurse.

2. The PCP or authorized attending physician must have performed a comprehensive (see Physician's Common Procedural Terminology for guidelines regarding comprehensive evaluation and management procedures) physical examination with medical history or history update within the 12 months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

211.200 Program Criteria for Home Health Services 7-1-17

A. A Medicaid beneficiary is eligible for home health services only if he or she has had a comprehensive physical examination and a medical history or history update by his or her PCP or authorized attending physician within the twelve months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

B. The appropriateness of home health services is determined by the beneficiary's PCP or authorized attending physician.

1. An individual's PCP or authorized attending physician determines whether the patient needs home health services, the scope and frequency of those services and the duration of the services.

2. The PCP or authorized attending physician is responsible for coordination of the patient's care, both in-home and outside the home.

C. Some examples of individuals for whom home health services may be suitable are those who need the following:

1. Specialized nursing procedures with regard to catheters or feeding tubes.

2. Detailed instructions regarding self-care or diet.

3. Rehabilitative services administered by a physical therapist.

D. Some beneficiaries may require home health services of very short duration while they or their caregiver receive training enabling them to provide for particular medical needs with little or no assistance from the home health agency.

E. Some individuals may need only intermittent monitoring or skilled care. When an individual's skilled care is so infrequent that more than 60 days elapse between services, that individual requires a new assessment and a new plan of care for each episode of care, unless the physician documents that the interval without such care is no detriment and appropriate to the treatment of the beneficiary's illness or injury.

211.300 Home Health Place of Service 7-1-17

Home health services may be provided in any normal setting in which normal life activities take place, other than a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting in which payment is or could be made under

Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound. The single exception to this policy permits Medicaid to reimburse a home health agency for providing nursing services to an ICF/IID resident on a short-term basis if the only alternative to home health services is inpatient admission to a hospital or a skilled nursing facility. Medicaid supplies, equipment and appliances suitable for use may be provided in any setting in which normal life activities take place.

212.150 Intravenous Therapy in a Patient's Home (Home IV Therapy) 7-1-17

Home IV therapy is a skilled nursing service that is included in coverage of LPN and RN home health visits. Home IV therapy is available to a Medicaid-eligible individual who is stabilized on a course of treatment and requires continued IV therapies in the home for several days or weeks. Medicaid requirements for establishing and maintaining home IV therapy are:

A. A Medicaid-eligible individual may qualify for home IV therapy only if he or she has had a face-to-face encounter with their physician or the allowed non-physician practitioner as prescribed in 206.000 (D).

B. The registered nurse employed by the Home Health provider must assess the patient and the patient's need for home IV therapy.

C. The PCP or authorized attending physician, in consultation with the Home Health provider, establishes and authorizes a home health plan of care that includes the physician's instructions for IV therapy.

D. The physician prescribes the IV drug(s).

1. Prescriptions for IV drugs are subject to applicable Medicaid Pharmacy program policy and Medicaid program benefit limits.
2. The client, the client's representative or the Home Health provider may obtain the drug(s) under the client's prescription drug benefit.
3. The pharmacy bills Medicaid or the patient, in accordance with Medicaid program policy, for the IV drugs.

E. The plan of care must include the following:

1. Details regarding the patient training that will occur, describing the type, the amount and the frequency of self-care the patient will learn and perform.
2. Realistic training goals.
3. The projected date by which skilled nursing care will end or decrease because the client will be capable of self-care or of a designated portion of her or his self-care.
    a. The registered nurse must visit and reassess the client before the projected date that the complete or partial self-care is to commence.
    b. The home health agency in consultation with the PCP or authorized attending physician must terminate or revise the plan of care, basing its determination on the degree of self-care of which the client has become capable.

F. The Home Health provider or a provider enrolled in the Arkansas Medicaid Prosthetics program may furnish the IV therapy supplies. Regardless of the source of the supplies, the Home Health provider is responsible for the deployment and management of the IV therapy supplies and for the documentation of their medical deployment and management.

G. The Home Health provider must report the patient's status to the PCP or authorized attending physician in accordance with the physician's prescribed schedule in the plan of care.

H. Nursing care in conjunction with IV therapy is in accordance with a home health plan of care, even if IV therapy is the only skilled service required and whether or not the client is receiving other home health services.

217.000 Registered Nurse Supervision of Home Health Aide Services 7-1-17

A. The supervising registered nurse must issue written instructions to the home health aide.

1. The instructions must specify the aide's specific duties at each visit.
2. The aide must note that he or she has performed each task and note, with written justification of the omission, which tasks he or she did not perform.

B. If a beneficiary is receiving home health aide services only, the registered nurse must visit the beneficiary at least once every 60 days to assess his or her condition and to evaluate the quality of service provided by the home health aide.

C. If a beneficiary is receiving only physical therapy and home health aide services, with no skilled nursing services, either the registered nurse or the qualified physical therapist may make this required supervisory visit.

242.430 Medical Supplies and Diapers/Underpads 7-1-17

When billing for these services, which are benefit-limited to a maximum number of dollars per month, providers must bill according to the **calendar** month. **Providers may not span calendar months when billing for medical supplies and diapers and underpads.** The date of delivery is the date of service. Providers may not enter different dates for "from" and "through" dates of service.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and that are required to address an individual medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – Prosthetics

EFFECTIVE DATE: July 1, 2017

SUBJECT: Provider Manual Update Transmittal PROSTHET-3-16

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
212.300	8-1-05	212.300	7-1-17

Explanation of Updates

Section 212.300 is updated with the definitions of medical supplies, equipment and appliances and to clarify policy regarding approved medical supplies, equipment and appliances.

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

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.

Dawn Stehle
Director

TOC not required

212.300 Medical Supplies, All Ages 7-1-17

The Arkansas Medicaid Program reimburses home health providers and prosthetics providers for covered medical supplies up to a maximum of $250.00 per month, per beneficiary. The $250.00 may be provided by the Home Health program, the Prosthetics program or a combination of the two.

A beneficiary may not receive more than a total of $250.00 of supplies per month unless an extension has been granted. Extensions will be considered for beneficiaries under age 21 in the Child Health Services (EPSDT) program if documentation verifies medical necessity.

A provider must request an extension of the benefit limit for a Medicaid beneficiary under age 21 by completing the Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21 (form DMS-602.) **View or print form DMS-602 and instructions for completion.**

The Arkansas Medicaid program covers medical supplies using a specific HCPCS procedure code for each specific item. Only supply items that are listed and have a corresponding payable HCPCS procedure code are covered.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and that are required to address an individual medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – Certified Nurse Midwife

EFFECTIVE DATE: July 1, 2017

SUBJECT: Provider Manual Update Transmittal CNM-1-16

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
—	—	204.100	7-1-2017
—	—	204.101	7-1-2017
—	—	204.102	7-1-2017
—	—	204.103	7-1-2017

Explanation of Updates

Section 204.100, Certified Nurse Midwife's Role in Home Health Services, has been created to detail PCP referral.

Section 204.101, Documentation of Services, has been created to inform of the records that must be maintained by Home Health providers.

Section 204.102, Plan of Care Review, has been created to detail the authorized attending physician's direction.

Section 204.103, Home Health Place of Service, has been created to briefly address policy concerning ICF/IID residents.

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

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.

Dawn Stehle /TAH

Dawn Stehle
Director

TOC required

204.100 Certified Nurse Midwife's Role in Home Health Services 7-1-2017

A. Home Health care requires a PCP referral except in the following circumstances:

1. Medicare/Medicaid dual-eligibles.
2. Obstetrician/gynecologists for postpartum complications.
3. To revise a plan of care during a period covered by a current referral; however, the agency must forward copies of the signed and dated assessment and the revision to the PCP.

B. A PCP may refer a beneficiary to a specific Home Health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.

1. PCPs, authorized attending physicians and Home Health agencies must maintain all required PCP referral documentation in the beneficiary's clinical records.
2. PCP referrals must be renewed when specified by the PCP or every 60 days, whichever period is shorter.

204.101 Documentation of Services 7-1-2017

Home Health Providers must maintain the following records for patients of all ages.

A. Patient assessments.

B. Plans of care.

C. Physical therapy evaluations.

D. Treatment plans when applicable.

E. Case notes.

F. Progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.

G. *Pro re natal* (PRN) visits and the medical justification for each such unscheduled visit.

H. A face-to-face encounter with the beneficiary must meet the following requirements:

1. Regarding initiation of Home Health services, the face-to-face encounter must be related to the primary reason the beneficiary requires Home Health services and must occur within the 90 days before or the 30 days after the start of services.
2. Regarding initiation of medical equipment, the face-to face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.
3. Conducted by one of the following practitioners:
   a. The primary care physician.
   b. A nurse practitioner working in collaboration with the primary care physician.
   c. A certified nurse midwife by the scope of practice.
   d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to A.C.A § 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.
   e. The attending acute or post-acute physician.

4. The non-physician must communicate the clinical findings of that face-to-face to the ordering physician. Those clinical findings must be incorporated into a document included in the beneficiary's medical record.
5. The physician ordering the services must assure clinical correlation between the face-to-face encounter and the associated Home Health document:
   a. The primary reason the patient requires Home Health services.
   b. The start of Home Health services.
   c. The practitioner who conducted the encounter and the date of the encounter.
   d. The face-to-face encounter may occur through telemedicine, when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies or appliances unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements as listed in D.3.

204.102 Plan of Care Review 7-1-2017

A. All Home Health services are at the direction of the patient's PCP or authorized attending physician.

B. The physician, in consultation with the patient and professional staff, is responsible for establishing the plan of care, specifying the type(s), frequency and duration of services.

C. Medicaid requires the PCP or authorized attending physician to review the patient's plan of care as often as necessary to address changes in the patient's condition -- but no less often than every 60 days.

1. The physician establishes the start date of each new, renewed or revised plan of care.
   a. A "renewed" plan of care has been reviewed in accordance with the 60-day requirement and has been authorized by the PCP or authorized attending physician to continue, either with or without revision.
   b. A "revised" plan of care is developed in response to a change in the patient's condition that necessitates prompt review by the physician and reassessment by the case nurse.
2. The PCP or authorized attending physician must have performed a comprehensive (see Physician's Common Procedural Terminology for guidelines regarding comprehensive evaluation and management procedures) physical examination with medical history or history update within the 12 months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

204.103 Home Health Place of Service 7-1-17

Home Health services may be provided in any normal setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home Health services cannot be limited to services furnished to beneficiaries who are homebound. The single exception to this policy permits Medicaid to reimburse a Home Health agency for providing nursing services to an ICF/IID resident on a short-term basis if the only alternative to Home Health services is inpatient admission to a hospital or a skilled nursing facility. Medicaid supplies, equipment and appliances suitable for use may be provided in any setting in which normal life activities take place.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – Nurse Practitioner

EFFECTIVE DATE: July 1, 2017

SUBJECT: Provider Manual Update Transmittal NURSEPRA-3-16

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
—	—	203.000	7-1-17
—	—	203.001	7-1-17
—	—	203.002	7-1-17
—	—	203.103	7-1-17
—	—	203.104	7-1-17
—	—	203.105	7-1-17
—	—	203.106	7-1-17
—	—	203.107	7-1-17
—	—	203.108	7-1-17

Explanation of Updates

Section 203.000, The Nurse Practitioner's Role in Home Health Services, has been created.

Section 203.001, Home Health and the Primary Care Physician (PCP) Case Management Program (ConnectCare), has been created to explain details of this program regarding PCP referral.

Section 203.002, Documentation of Services, has been created to detail information regarding the health records and related documentation that must be maintained for beneficiaries of Home Health Services.

Section 203.103, Plan of Care Review, has been created to detail information on the responsibilities of the PCP or authorized attending physician regarding the Home Health beneficiary's plan of care.

Section 203.104, Program Criteria for Home Health Services, has been created to detail information regarding eligibility requirements of a Medicaid beneficiary for Home Health Services.

Section 203.105, Home Health Place of Service, has been created to detail information on the characteristics of a place of service that qualifies as a setting for home health care.

Section 203.106, Intravenous Therapy in a Patient's Home (Home IV Therapy), has been created to detail information regarding the Medicaid requirements for establishing and maintaining home IV therapy for a Home Health beneficiary.

Section 203.107, Registered Nurse Supervision of Home Health Aide Services, has been created to detail information on the requirements of the assigned registered nurse regarding supervision of the home health aide.

Section 203.108, Medical Supplies and Diapers/Underpads, has been created to detail information on the billable items associated with a Home Health beneficiary.

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 Hewlett Packard Enterprise 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 the Program Development and Quality Assurance Unit at (501) 320-6429.

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.

Dawn Stehle
Director

TOC required

203.000 The Nurse Practitioner's Role in Home Health Services 7-1-17

203.010 Home Health and the Primary Care Physician (PCP) Case Management Program (ConnectCare) 7-1-17

A. Home health care requires a PCP referral except in the following circumstances:

1. Medicaid does not require Medicare beneficiaries to enroll with PCPs; therefore, a PCP referral is not required for home health services for Medicare/Medicaid dual-eligibles.
2. Obstetrician/gynecologists may authorize and direct medically-necessary home health care for postpartum complications without obtaining a PCP referral.

B. A PCP may refer a beneficiary to a specific home health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.

1. PCPs, authorized attending physicians and home health agencies must maintain all required PCP referral documentation in the beneficiary's clinical records.
2. PCP referrals must be renewed when specified by the PCP or every 60 days, whichever period is shorter.

C. PCP referral is not required to revise a plan of care during a period covered by a current referral, but the agency must forward copies of the signed and dated assessment and the revision to the PCP.

203.020 Documentation of Services 7-1-17

Home Health providers must maintain the following records for patients of all ages:

A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans, when applicable.

B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapists and physical therapy assistants.

C. Signed and dated documentation of *pro re nata* (PRN) visits, which must include the following:

1. The medical justification for each such unscheduled visit.
2. The patient's vital signs and symptoms.
3. The observations of and measures taken by agency staff and reported to the physician.
4. The physician's comments, observations and instructions.

D. Verification, by means of physician or approved non-physician practitioner documentation that there was a face-to-face encounter with the beneficiary that meets the following requirements:

1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or the 30 days after the start of services.
2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.
3. The face-to-face encounter may be conducted by one of the following practitioners:

a. The primary care physician;

b. A nurse practitioner working in collaboration with the primary care physician;

c. A certified nurse midwife by the scope of practice;

d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.

e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

4. The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that encounter to the ordering physician. These clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician ordering the services must:

a. Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required timeframes prior to the start of home health services.

b. Indicate the practitioner who conducted the encounter, and the date of the encounter.

6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in D.3. with the exception of nurse-midwives.

F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications.

G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.

H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.

I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

203.030 Plan of Care Review 7-1-17

A. All home health services are at the direction of the patient's PCP or authorized attending physician.

B. The physician, in consultation with the patient and professional staff, is responsible for establishing the plan of care, specifying the type(s), frequency and duration of services.

C. Medicaid requires the PCP or authorized attending physician to review the patient's plan of care as often as necessary to address changes in the patient's condition, but no less often than every 60 days.

1. The physician establishes the start date of each new, renewed or revised plan of care. A "renewed" plan of care is a plan of care that has been reviewed in accordance with the 60-day requirement and has been authorized by the PCP or authorized attending physician to continue, either with or without revision. A "revised" plan of care is a plan of care developed in response to a change in the patient's condition that necessitates prompt review by the physician and reassessment by the case nurse.

2. The PCP or authorized attending physician must have performed a comprehensive (see Physician's Common Procedural Terminology for guidelines regarding comprehensive evaluation and management procedures) physical examination with medical history or history update within the 12 months preceding the start date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

203.040 Program Criteria for Home Health Services 7-1-17

A. A Medicaid beneficiary is eligible for home health services only if he or she has had a comprehensive physical examination and a medical history or history update by his or her PCP or authorized attending physician within the twelve months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

B. The appropriateness of home health services is determined by the beneficiary's PCP or authorized attending physician.

1. An individual's PCP or authorized attending physician determines whether the patient needs home health services, the scope and frequency of those services and the duration of the services.

2. The PCP or authorized attending physician is responsible for coordination of the patient's care, both in-home and outside the home.

C. Some examples of individuals for whom home health services may be suitable are those who need the following:

1. Specialized nursing procedures with regard to catheters or feeding tubes.

2. Detailed instructions regarding self-care or diet.

3. Rehabilitative services administered by a physical therapist.

D. Some beneficiaries may require home health services of very short duration while they or their caregivers receive training enabling them to provide for particular medical needs with little or no assistance from the home health agency.

E. Some individuals may need only intermittent monitoring or skilled care. When an individual's skilled care is so infrequent that more than 60 days elapse between services, that individual requires a new assessment and a new plan of care for each episode of care, unless the physician documents that the interval without such care is no detriment and appropriate to the treatment of the beneficiary's illness or injury.

203.050 Home Health Place of Service 7-1-17

Home health services may be provided in any normal setting in which normal life activities take place, other than a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting in which payment is or could be made under

Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound. The single exception to this policy permits Medicaid to reimburse a home health agency for providing nursing services to an ICF/IID resident on a short-term basis if the only alternative to home health services is inpatient admission to a hospital or a skilled nursing facility. Medicaid supplies, equipment and appliances suitable for use may be provided in any setting in which normal life activities take place.

203.060 Intravenous Therapy in a Patient's Home (Home IV Therapy) 7-1-17

Home IV therapy is a skilled nursing service that is included in coverage of LPN and RN home health visits. Home IV therapy is available to a Medicaid-eligible individual who is stabilized on a course of treatment and requires continued IV therapies in the home for several days or weeks. Medicaid requirements for establishing and maintaining home IV therapy are:

A. **A Medicaid-eligible individual may qualify for home IV therapy only if he or she has had a face-to-face encounter with their physician or the allowed non-physician practitioner.**

B. The registered nurse employed by the Home Health provider must assess the patient and the patient's need for home IV therapy.

C. The PCP or authorized attending physician, in consultation with the Home Health provider, establishes and authorizes a home health plan of care that includes the physician's instructions for IV therapy.

D. The physician prescribes the IV drug(s).

1. Prescriptions for IV drugs are subject to applicable Medicaid Pharmacy program policy and Medicaid program benefit limits.
2. The client, the client's representative or the Home Health provider may obtain the drug(s) under the client's prescription drug benefit.
3. The pharmacy bills Medicaid or the patient, in accordance with Medicaid program policy, for the IV drugs.

E. The plan of care must include the following:

1. Details regarding the patient training that will occur, describing the type, the amount and the frequency of self-care the patient will learn and perform.
2. Realistic training goals.
3. The projected date by which skilled nursing care will end or decrease because the client will be capable of self-care or of a designated portion of her or his self-care.
   a. The registered nurse must visit and reassess the client before the projected date that the complete or partial self-care is to commence.
   b. The home health agency in consultation with the PCP or authorized attending physician must terminate or revise the plan of care, basing its determination on the degree of self-care of which the client has become capable.

F. The Home Health provider or a provider enrolled in the Arkansas Medicaid Prosthetics program may furnish the IV therapy supplies. Regardless of the source of the supplies, the Home Health provider is responsible for the deployment and management of the IV therapy supplies and for the documentation of their medical deployment and management.

G. The Home Health provider must report the patient's status to the PCP or authorized attending physician in accordance with the physician's prescribed schedule in the plan of care.

203.070 Registered Nurse Supervision of Home Health Aide Services 7-1-17

A. The supervising registered nurse must issue written instructions to the home health aide.

1. The instructions must specify the aide's specific duties at each visit.
2. The aide must note that he or she has performed each task and note, with written justification of the omission, which tasks he or she did not perform.

B. If a beneficiary is receiving home health aide services only, the registered nurse must visit the beneficiary at least once every 60 days to assess his or her condition and to evaluate the quality of service provided by the home health aide.

C. If a beneficiary is receiving only physical therapy and home health aide services, with no skilled nursing services, either the registered nurse or the qualified physical therapist may make this required supervisory visit.

203.080 Medical Supplies and Diapers/Underpads 7-1-17

When billing for these services, which are benefit-limited to a maximum number of dollars per month, providers must bill according to the **calendar** month. **Providers may not span calendar months when billing for medical supplies and diapers and underpads.** The date of delivery is the date of service. Providers may not enter different dates for "from" and "through" dates of service.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and are required to address an individual medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.