26. Personal Care

A. Personal care services are provided by a personal care aide to assist with a client's physical dependency needs. The personal care aide must have at least 24 hours classroom training and a minimum of supervised practical training of 16 hours provided by or under the supervision of a registered nurse for a total of no less than 40 hours.

B. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are –

1. Authorized for the individual in accordance with a service plan approved by the State;
2. Provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and
3. Furnished in a home, and at the State's option, in another location, including licensed residential care facilities and licensed assisted living facilities.

C. The State defines "a member of the individual's family" as:

1. A spouse,
2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent,
3. A minor's "guardian of the person" or anyone acting as a minor's "guardian of the person" or
4. An adult's "guardian of the person" or anyone acting as an adult's "guardian of the person".

D. Personal care services are covered for categorically needy individuals only.

E. Personal care services are medically necessary, prescribed services to assist clients with their physical dependency needs.

1. Personal care services involve "hands-on" assistance, by a personal care aide, with a client's physical dependency needs (as opposed to purely housekeeping services).
2. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the client were in a hospital or nursing facility.

F. Prior authorization is required for personal care **pursuant to the Independent Assessment** for **all** beneficiaries.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: ~~October 1, 2012~~ January 1, 2018

CATEGORICALLY NEEDY

26. Personal Care

A. Personal care services are provided by a personal care aide to assist with a client's physical dependency needs. The personal care aide must have at least 24 hours classroom training and a minimum of supervised practical training of 16 hours provided by or under the supervision of a registered nurse for a total of no less than 40 hours.

B. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are –

1. Authorized for the individual ~~by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual~~ in accordance with a service plan approved by the State;
2. Provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and
3. Furnished in a home, and at the State's option, in another location, including licensed residential care facilities and licensed assisted living facilities.

C. The State defines "a member of the individual's family" as:

1. A spouse,
2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent,
3. A minor's "guardian of the person" or anyone acting as a minor's "guardian of the person" or
4. An adult's "guardian of the person" or anyone acting as an adult's "guardian of the person".

D. Personal care services are covered for categorically needy individuals only.

E. Personal care services are medically necessary, prescribed services to assist clients with their physical dependency needs.

1. Personal care services involve "hands-on" assistance, by a personal care aide, with a client's physical dependency needs (as opposed to purely housekeeping services).
2. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the client were in a hospital or nursing facility.

F. Prior authorization is required for personal care pursuant to the Independent Assessment ~~-~~for all beneficiaries ~~under age 21.~~

G. ~~Effective for dates of service on or after April 1, 2002, for services beyond 64 hours per calendar month per beneficiary aged 21 or older, the provider must request a benefit extension. Extensions of the personal care benefit will be provided for beneficiaries aged 21 and older when extended benefits are determined to be medically necessary.~~

ARKANSAS DEPARTMENT OF HUMAN SERVICES

**Division of Medical Services**
**Program Development & Quality Assurance**

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

**TO:** Arkansas Medicaid Health Care Providers – ARChoices In Homecare Home and Community-Based 2176 Waiver

**EFFECTIVE DATE:** January 1, 2018

**SUBJECT:** Provider Manual Update Transmittal ARCHOICES-1-17

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 213.230 | 1-1-16 | 213.230 | 1-1-18 |
| 213.311 | 10-1-16 | 213.311 | 1-1-18 |
| 213.323 | 10-1-16 | 213.323 | 1-1-18 |

**Explanation of Updates**

Sections 213.230, 213.311, and 213.323 have been updated to add certification requirements to Attendant Care Services Providers, Hot Home-Delivered Meal Providers and Frozen Home-Delivered Meal Providers.

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 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*

**213.230 Attendant Care Services Certification Requirements 1-1-18**

The following requirements must be met prior to certification by the Division of Aging and Adult Services (DAAS) by providers of attendant care services. The provider must:

A. Hold a current Arkansas State Board of Health Class A and/or Class B license, Or Private Care Agency license.

B. All owners, principals, employees, and contract staff of an attendant care services provider must submit to an independent, national criminal background check, identity verification and fingerprinting. Background checks must be repeated every three years.

C. Employ and supervise direct care staff who:

1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
2. Possess the necessary skills to perform the specific services required to meet the needs of the beneficiary the direct care staff member is to serve; and
3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and DAAS certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DAAS every three years; however, the provider must submit a copy the agency's current license to DAAS each year when the license is renewed.

Providers are required to submit copy of renewed license to DAAS.

**NOTE: The Class A, Class B or Private Care Agency license provider's ElderChoices and AAPD certification will be valid as an Attendant Care services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices and AAPD.**

**213.311 Hot Home-Delivered Meal Provider Certification Requirements 1-1-18**

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of Hot Home-Delivered Meal services, a provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAAS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, assure that the provider's intermediate source of delivery meets or exceeds federal, state and local laws regarding food transportation and delivery;*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law;*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

E. All owners, principals, employees, and contract staff of a hot, home-delivered meal services provider must submit to an independent, national criminal background check, identity verification and fingerprinting. Background checks must be repeated every three years.

F. Notify the DAAS RN immediately if:

1. There is a problem with delivery of service
2. The beneficiary is not consuming the meals
3. A change in the individual's condition is noted

**NOTE: Changes in service delivery must receive prior approval by the DAAS RN who is responsible for the individual's Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the DAAS RN. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.**

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Hot Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.

**NOTE: The Home-Delivered Meals provider's ElderChoices certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**



**213.323 Frozen Home-Delivered Meal Provider Certification Requirements 1-1-18**

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the Division of Aging and Adult Services (DAAS) Nutrition Services Program Policy Number 206.

To be certified by DAAS as a provider of Home-Delivered Meal services, a meal provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAAS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

E. All owners, principals, employees, and contract staff of a home-delivered meal services provider must submit to an independent, national criminal background check, identity verification and fingerprinting. Background checks must be repeated every three years.

~~E.~~ F. Provide frozen meals that:

1. Were prepared or purchased according to the Department of Health and DAAS Nutrition Services Program Policy guidelines in freezer-safe containers that can be reheated in the oven or microwave.
2. Are kept frozen from the time of preparation through placement in the individual's freezer.
3. Have a remaining freezer life of at least three months from the date of delivery to the home.
4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ARChoices beneficiary), menu analysis as required by DAAS Nutrition Services Program Policy if other than DAAS menus are used and both packaging and expiration dates.

**NOTE: The milk must be delivered to the beneficiary at least seven (7) days prior to its expiration date.**

F. Instruct each individual, both verbally and in writing, in the handling and preparation required for frozen meals and provide written re-heating instructions with each meal, preferably in large print.

G. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:

1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
2. Are prepared specifically to be frozen;
3. Are frozen as quickly as possible;
4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
7. Are frozen in a manner that allows air circulation around each individual tray;
8. Are kept frozen throughout storage, transport and delivery to the beneficiary; and
9. Are discarded after 30 days.

H. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by DAAS. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.

I. Notify the appropriate DAAS RN immediately if:

1. There is a problem with delivery of service
2. The individual is not consuming the meals
3. A change in an individual's condition is noted

**NOTE: Changes in service delivery must receive prior approval by the DAAS RN who is responsible for the individual's Person-Centered Services Plan (PCSP). Requests must be submitted in writing to the DAAS RN. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.**

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Frozen Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.

**NOTE: The Home-Delivered Meals ElderChoices provider's certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**

*TOC not required*

**213.230 Attendant Care Services Certification Requirements** ~~1-1-161-1-18~~

The following requirements must be met prior to certification by the Division of Aging and Adult Services (DAAS) by providers of attendant care services. The provider must:

A. Hold a current Arkansas State Board of Health Class A and/or Class B license, Or Private Care Agency license.

B. All owners, principals, employees, and contract staff of an attendant care services provider must submit to an independent, national criminal background check, identity verification and fingerprinting. Background checks must be repeated every three years.

~~B~~C. Employ and supervise direct care staff who:

1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
2. Possess the necessary skills to perform the specific services required to meet the needs of the beneficiary the direct care staff member is to serve; and
3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and DAAS certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DAAS every three years; however, the provider must submit a copy the agency's current license to DAAS each year when the license is renewed.

Providers are required to submit copy of renewed license to DAAS.

**NOTE: The Class A, Class B or Private Care Agency license provider's ElderChoices and AAPD certification will be valid as an Attendant Care services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices and AAPD.**

**213.311 Hot Home-Delivered Meal Provider Certification Requirements** **10-1-~~16~~17**

To be certified by the Division of Aging and Adult Services (DAAS) as a provider of Hot Home-Delivered Meal services, a provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAAS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, assure that the provider's intermediate source of delivery meets or exceeds federal, state and local laws regarding food transportation and delivery;*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law;*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

E. All owners, principals, employees, and contract staff of a hot, home-delivered meal services provider must submit to an independent, national criminal background check, identity verification and fingerprinting. Background checks must be repeated every three years.

~~E~~F. Notify the DAAS RN immediately if:

1. There is a problem with delivery of service
2. The beneficiary is not consuming the meals
3. A change in the individual's condition is noted

**NOTE: Changes in service delivery must receive prior approval by the DAAS RN who is responsible for the individual's Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the DAAS RN. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.**

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Hot Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.

**NOTE: The Home-Delivered Meals provider's ElderChoices certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**



**213.323 Frozen Home-Delivered Meal Provider Certification Requirements 10-1-4617**

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the Division of Aging and Adult Services (DAAS) Nutrition Services Program Policy Number 206.

To be certified by DAAS as a provider of Home-Delivered Meal services, a meal provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAAS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

C. If applicable, ensure that intermediate sources of delivery meet or exceed federal, state and local laws regarding food transportation and delivery*

D. Procure and have available all necessary licenses, permits and food handlers' cards as required by law*

***NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.**

E. All owners, principals, employees, and contract staff of a home-delivered meal services provider must submit to an independent, national criminal background check, identity verification and fingerprinting. Background checks must be repeated every three years.

~~E~~F. Provide frozen meals that:

1. Were prepared or purchased according to the Department of Health and DAAS Nutrition Services Program Policy guidelines in freezer-safe containers that can be reheated in the oven or microwave.
2. Are kept frozen from the time of preparation through placement in the individual's freezer.
3. Have a remaining freezer life of at least three months from the date of delivery to the home.
4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).
5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ARChoices beneficiary), menu analysis as required by DAAS Nutrition Services Program Policy if other than DAAS menus are used and both packaging and expiration dates.

**NOTE: The milk must be delivered to the beneficiary at least seven (7) days prior to its expiration date.**

F. Instruct each individual, both verbally and in writing, in the handling and preparation required for frozen meals and provide written re-heating instructions with each meal, preferably in large print.

G. Ensure that meals that are not commercially prepared but produced on-site in the production kitchen:

1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;
2. Are prepared specifically to be frozen;
3. Are frozen as quickly as possible;
4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;
5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;
6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;
7. Are frozen in a manner that allows air circulation around each individual tray;
8. Are kept frozen throughout storage, transport and delivery to the beneficiary; and
9. Are discarded after 30 days.

H. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by DAAS. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.

l. Notify the appropriate DAAS RN immediately if:

1. There is a problem with delivery of service
2. The individual is not consuming the meals
3. A change in an individual's condition is noted

**NOTE: Changes in service delivery must receive prior approval by the DAAS RN who is responsible for the individual's Person-Centered Services Plan (PCSP). Requests must be submitted in writing to the DAAS RN. Any changes in the individual's circumstances must be reported to the DAAS RN via form AAS-9511.**

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary's PCSP only when they are necessary to prevent the institutionalization of an individual.

Frozen Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain a copy of the agency's current Food Establishment Permit at all times.

**NOTE: The Home-Delivered Meals ElderChoices provider's certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

**Division of Medical Services**
**Program Development & Quality Assurance**

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TDD/TTY: 501-682-6789

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

**EFFECTIVE DATE:** **January 1, 2018**

**SUBJECT:** **Provider Manual Update Transmittal HOMEHLTH-1-17**

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 201.000 | 11-1-09 | 201.000 | 1-1-18 |

**Explanation of Updates**

Section 201.000 is updated to include a background check requirement for home health providers.

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 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*

## 201.000 Arkansas Medicaid Participation Requirements for Home Health Providers 1-1-18

Home Health 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. Only home health agencies licensed to operate in Arkansas may participate in the Arkansas Medicaid Home Health Program.

B. A provider participating in the Arkansas Medicaid Home Health Program must be currently licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.

C. A provider participating in the Arkansas Medicaid Home Health Program must be currently certified by the Arkansas Home Health State Survey Agency as a participant in the Title XVIII (Medicare) Program.

D. Providers participating in the Arkansas Medicaid Home Health Program must maintain documentation of current licensure and certification in their Medicaid provider enrollment files.

E. All owners, principals, employees, and contract staff of a home health provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

Enrolled providers must submit copies of license and certification renewals to the Provider Enrollment Unit, Division of Medical Services (DMS), within 30 days of the issuance of those documents. **View or print Provider Enrollment Unit contact information.**

Markup

*TOC not required*

**201.000 Arkansas Medicaid Participation Requirements for Home Health Providers** ~~11-1-09~~1-1-18

Home Health 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. Only home health agencies licensed to operate in Arkansas may participate in the Arkansas Medicaid Home Health Program.

B. A provider participating in the Arkansas Medicaid Home Health Program must be currently licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.

C. A provider participating in the Arkansas Medicaid Home Health Program must be currently certified by the Arkansas Home Health State Survey Agency as a participant in the Title XVIII (Medicare) Program.

D. Providers participating in the Arkansas Medicaid Home Health Program must maintain documentation of current licensure and certification in their Medicaid provider enrollment files.

E. All owners, principals, employees, and contract staff of a home health provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

Enrolled providers must submit copies of license and certification renewals to the Provider Enrollment Unit, Division of Medical Services (DMS), within 30 days of the issuance of those documents. **View or print Provider Enrollment Unit contact information.**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

**Division of Medical Services**
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TDD/TTY: 501-682-6789

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

**EFFECTIVE DATE:** **January 1, 2018**

**SUBJECT:** **Provider Manual Update Transmittal EPSDT-1-17**

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 211.000 | 1-15-11 | 211.000 | 1-1-18 |

**Explanation of Updates**

Section 211.100 is updated to include the independent assessment requirement for personal care services.

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 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

Dawn Stehle
Director

*TOC not required*

## 211.000 Introduction 1-1-18

A comprehensive medical screening program for all eligible Medicaid children requires the medical provider to assume overall responsibility for detection and treatment of conditions found among these young patients. This means the provider should have knowledge of specialized referral services available within the community and should maintain continuing relationships with physician specialists. It also requires the provider to work closely with the Arkansas Department of Human Services office staff to ensure that eligible children in need of medical attention take full advantage of the medical services available to them. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information.

The screening procedures outlined in Sections 213.000 and 215.000 of this manual are considered the minimal elements of a comprehensive screening. Other procedures may be included depending upon the child's age and health history. Each of the screening procedures is based on recommendations from the federal Department of Health and Human Services and the American Academy of Pediatrics. Each screening should be billed separately, providing the appropriate information for each of the applicable screening components. Other specific procedures may be used at the screener's discretion as long as the following federally mandated components are included in the complete medical screening procedure: observe and measure growth and development, give nutritional advice, immunize, counsel and give health education and perform laboratory procedures applicable for the age of the child.

Requirements for Periodic Medical, Visual, Hearing and Dental Screenings
Distinct periodicity schedules have been established for medical screening services, vision services, hearing services and dental services (i.e., each of these services has its own periodicity schedule). Periodic visual, hearing and dental screens should not duplicate prior services.

*TOC not required*

Markup

**211.000 Introduction** ~~1-15-11~~1-1-18

A comprehensive medical screening program for all eligible Medicaid children requires the medical provider to assume overall responsibility for detection and treatment of conditions found among these young patients. This means the provider should have knowledge of specialized referral services available within the community and should maintain continuing relationships with physician specialists. It also requires the provider to work closely with the Arkansas Department of Human Services office staff to ensure that eligible children in need of medical attention take full advantage of the medical services available to them. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information.

The screening procedures outlined in Sections 213.000 and 215.000 of this manual are considered the minimal elements of a comprehensive screening. Other procedures may be included depending upon the child's age and health history. Each of the screening procedures is based on recommendations from the federal Department of Health and Human Services and the American Academy of Pediatrics. Each screening should be billed separately, providing the appropriate information for each of the applicable screening components. Other specific procedures may be used at the screener's discretion as long as the following federally mandated components are included in the complete medical screening procedure: observe and measure growth and development, give nutritional advice, immunize, counsel and give health education and perform laboratory procedures applicable for the age of the child.

Requirements for Periodic Medical, Visual, Hearing and Dental Screenings

Distinct periodicity schedules have been established for medical screening services, vision services, hearing services and dental services (i.e., each of these services has its own periodicity schedule). Periodic visual, hearing and dental screens should not duplicate prior services.

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 – Hospice Service

**EFFECTIVE DATE:** January 1, 2018

**SUBJECT:** Provider Manual Update Transmittal HOSPICE-1-17

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 201.100 | 11-1-09 | 201.100 | 1-1-18 |
| 211.101 | 1-1-13 | 211.101 | 1-1-18 |

**Explanation of Updates**

Section 201.100 is updated to include a background check requirement under the enrollment criteria for hospice service providers.

Section 211.101 is updated to include the independent assessment requirement for personal care services.

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 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.

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Thank you for your participation in the Arkansas Medicaid Program.



Dawn Stehle
Director

*TOC not required*

**201.100 Enrollment Criteria** 1-1-18

Hospice Services 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. The hospice provider must be certified as a Title XVIII (Medicare) hospice provider. The provider must submit a copy of the Medicare certification to Provider Enrollment when submitting the Hospice Program application and contract.

B. The hospice provider must be licensed by the Division of Health Facility Services, Arkansas Division of Health. The provider must submit a copy of their current license.

C. All Medicaid-enrolled hospice providers that employ or contract physicians to provide direct patient care to Medicaid-eligible hospice patients must be enrolled as hospice physician billing intermediaries in order to bill Medicaid for hospice physician. See Section 240.200 for additional information regarding this requirement.

D. All owners, principals, employees, and contract staff of a hospice provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

**211.101 Personal Care/Hospice Policy Clarification** 1-1-18

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice aide and homemaker services.

A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in home providers.

B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aide and homemaker services necessary for the treatment of the terminal condition.

C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

Prior Authorization for personal care for beneficiaries receiving both hospice services and personal care services will be considered based on the individual beneficiary's physical dependency needs. Requests for personal care services require an Independent Assessment to determine medical necessity and to assure duplication of services will be adjusted accordingly. Please refer to the Independent Assessment Guide for related information.

**NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice care in the home that provides the amount of services required to meet the needs of the beneficiary, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.**

TOC not required

**201.100 Enrollment Criteria** ~~11-1-091-1-18~~

Hospice Services 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. The hospice provider must be certified as a Title XVIII (Medicare) hospice provider. The provider must submit a copy of the Medicare certification to Provider Enrollment when submitting the Hospice Program application and contract.

B. The hospice provider must be licensed by the Division of Health Facility Services, Arkansas Division of Health. The provider must submit a copy of their current license.

C. All Medicaid-enrolled hospice providers that employ or contract physicians to provide direct patient care to Medicaid-eligible hospice patients must be enrolled as hospice physician billing intermediaries in order to bill Medicaid for hospice physician. See Section 240.200 for additional information regarding this requirement.

D. All owners, principals, employees, and contract staff of a hospice provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

**211.101 Personal Care/Hospice Policy Clarification** ~~1-1-131-1-18~~

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice aide and homemaker services.

A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in home providers.

B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aide and homemaker services necessary for the treatment of the terminal condition.

C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the IndependentChoices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

~~Extension of benefits~~Prior Authorization for personal care for beneficiaries receiving both hospice services and personal care services will be considered based on the individual beneficiary's physical dependency needs. ~~Requests for increased personal care hours will be reviewed for medical necessity; duplication of services will be adjusted accordingly~~Requests for personal care

services require an Independent Assessment to determine medical necessity and to assure duplication of services will be adjusted accordingly. Please refer to the Independent Assessment Guide for related information.

**NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice care in the home that provides the amount of services required to meet the needs of the beneficiary, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.**

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

**EFFECTIVE DATE:** January 1, 2018

**SUBJECT:** Provider Manual Update Transmittal Secl-3-17

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 171.400 | 4-1-06 | 171.400 | 1-1-18 |

**Explanation of Updates**

Section 171.400 is updated to include the Independent Assessment requirement for personal care services.

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 Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.



Dawn Stehle
Director

*TOC not required*

**171.400 PCP Referrals** **1-1-18**

A. Referrals may be only for medically necessary services, supplies or equipment.

B. Enrollee free choice by naming two or more providers of the same type or specialty.

C. PCPs are not required to make retroactive referrals.

D. Since PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.

E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)

F. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and at least every six months (with exceptions as noted in part E, above).

G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.

I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

*TOC not required*

**171.400 PCP Referrals** ~~4-1-061-1-~~ **18**

A. Referrals may be only for medically necessary services, supplies or equipment.

B. Enrollee free choice by naming two or more providers of the same type or specialty.

C. PCPs are not required to make retroactive referrals.

D. Since PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.

E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)

F. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and at least every six months (with exceptions as noted in part E, above).

G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.

I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

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

**EFFECTIVE DATE:** January 1, 2018

**SUBJECT:** Provider Manual Update Transmittal PERSCARE-1-17

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 200.100 | 8-1-04 | 200.100 | 1-1-18 |
| 200.130 | 1-1-16 | 200.130 | 1-1-18 |
| 201.120 | 3-1-05 | 201.120 | 1-1-18 |
| 202.200 | 3-1-11 | 202.200 | 1-1-18 |
| 212.000 | 10-13-03 | 212.000 | 1-1-18 |
| 213.000 | 1-1-16 | 213.000 | 1-1-18 |
| 213.200 | 7-22-10 | 213.200 | 1-1-18 |
| 213.540 | 7-15-12 | 213.540 | 1-1-18 |
| 213.600 | 3-1-11 | 213.600 | 1-1-18 |
| 214.000 | 1-1-13 | — | — |
| 214.100 | 1-1-13 | — | — |
| 214.110 | 1-1-13 | — | — |
| 214.200 | 1-1-13 | 214.200 | 1-1-18 |
| 214.300 | 1-1-16 | 214.300 | 1-1-18 |
| 214.320 | 1-1-16 | 214.320 | 1-1-18 |
| 215.100 | 1-1-16 | 215.100 | 1-1-18 |
| 215.300 | 10-13-03 | 215.300 | 1-1-18 |
| 215.310 | 10-13-03 | 215.310 | 1-1-18 |
| 215.320 | 10-13-03 | 215.320 | 1-1-18 |
| 215.330 | 10-13-03 | 215.330 | 1-1-18 |
| 215.340 | 10-13-03 | 215.340 | 1-1-18 |
| 215.351 | 10-1-07 | 215.351 | 1-1-18 |
| 216.000 | 1-1-13 | 216.000 | 1-1-18 |
| 216.212 | 10-13-03 | 216.212 | 1-1-18 |
| 216.220 | 10-13-03 | 216.220 | 1-1-18 |
| 216.230 | 10-13-03 | 216.230 | 1-1-18 |
| 216.240 | 10-13-03 | 216.240 | 1-1-18 |
| 217.100 | 10-13-03 | 217.100 | 1-1-18 |

| | | | |
|---|---|---|---|
| 217.120 | 1-1-13 | 217.120 | 1-1-18 |
| 221.000 | 1-1-13 | 221.000 | 1-1-18 |
| 240.000 | 10-13-03 | 240.000 | 1-1-18 |
| 241.000 | 7-1-15 | 241.000 | 1-1-18 |
| 242.000 | 7-1-15 | 242.000 | 1-1-18 |
| 243.000 | 10-1-08 | 243.000 | 1-1-18 |
| 244.000 | 1-1-13 | 244.000 | 1-1-18 |
| 262.410 | 9-1-14 | 262.410 | 1-1-18 |

**Explanation of Updates**

Section 200.100 has been updated to change background check requirements.

Section 200.130 has been updated to change the requirements for Private Care Agencies.

Section 201.120 has been updated to add new information regarding Private Care Agencies.

Section 202.200 has been updated to change who can authorize personal care services for beneficiaries traveling out-of-state.

Section 212.000 has been updated to change Program Purpose information.

Section 213.000 has been updated to change Program Scope information.

Section 213.200 has been updated to change the beneficiary's physician to DHS professional staff or contractor(s) designated by DHS.

Section 213.540 has been updated to change the prior authorization requirement for Employment-related Personal Care Outside the Home.

Section 213.600 has been updated to change the beneficiary's physician to DHS professional staff or contractor(s) designated by DHS.

Sections 214.000 (The Physician's Role in Personal Care), 214.100 (Physician Authorization of Personal Care Services), and 214.110 (The Physician's Notification of Service Plan Authorization) have been removed and their contents deleted.

Section 214.200 has been updated to change Service Plan Review and Renewal requirements.

Section 214.300 has been updated to change authorization information regarding ARChoices Plan of Care and Personal Care Services Plan.

Section 214.320 has been updated to change the requirements for ARChoices Plan of Care revisions.

Section 215.100 has been updated to change Assessment and Service Plan Format requirements.

Section 215.300 has been updated to change Service Plan requirements.

Section 215.310 has been updated to change the beneficiary's physician to DHS professional staff or contractor(s) designated by DHS.

Section 215.320 has been updated to change Service Initiation and Service Initiation Delay requirements.

Section 215.330 has been updated to change Service Plan Revision requirements.

Section 215.340 has been updated to change Termination of Services requirements.

Section 215.351 has been updated to change Service Plan Requirements for Multiple Providers.

Section 216.000 has been updated to Coverage information.

Section 216.212 has been updated to change information regarding meal consumption.

Section 216.220 has been updated to change information regarding bathing.

Section 216.230 has been updated to change information regarding dressing.

Section 216.240 has been updated to change information regarding personal hygiene.

Section 217.100 has been updated to remove the signature requirement of the beneficiary's PCP or attending physician for Benefit Extension Requests for Beneficiaries Aged 21 and Older.

Sections 217.120 and 221.000 have been updated to change information regarding service authorizations.

Sections 240.000, 241.000, 242.000, 243.000, and 244.000 have been updated to change the prior authorization requirements, responsibilities, and instructions.

Section 262.410 has been updated to change Field 31 in the CMS-1500 Instructions.

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Dawn Stehle

Dawn Stehle
Director

| Field Name and Number | Instructions for Completion |
|---|---|
| 25. FEDERAL TAX I.D. NUMBER | Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly. |
| 26. PATIENT'S ACCOUNT NO. | Optional entry for providers' accounting and account-retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set appears on the Remittance Advice as "MRN." |
| 27. ACCEPT ASSIGNMENT? | Not required. Assignment is automatically accepted by the provider when billing Medicaid. |
| 28. TOTAL CHARGE | Total of Column 24F—the sum of all charges on the claim. |
| 29. AMOUNT PAID | Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid. |
| 30. RESERVED | Reserved for NUCC use. |
| 31. SIGNATURE OF ~~PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS~~PROVIDER | The performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A "provider's signature" is the provider's or authorized individual's personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed. |
| 32. SERVICE FACILITY LOCATION INFORMATION | If services were not performed at the beneficiary's home or at the provider's facility (*e.g.*, school, DDS facility etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job-seeking), indicate "multiple locations" or leave blank. |
| a. (blank) | Not required. |
| b. (blank) | Not required. |
| 33. BILLING PROVIDER INFO & PH # | Billing provider's name and complete address. Telephone number is requested but not required. |
| a. (blank) | Not required. |
| b. (blank) | Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider. |

| Field Name and Number | | Instructions for Completion |
|---|---|---|
| 24A. | DATE(S) OF SERVICE | The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.<br>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.<br>2. A provider may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the date sequence.<br>3. RCFs may bill for a date span of any length within the same calendar month, provided the beneficiary was present every day of the date span and all services provided within the date span were at the same Level of Care. |
| B. | PLACE OF SERVICE | Two-digit national standard place of service code. |
| C. | EMG | Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency. |
| D. | PROCEDURES, SERVICES, OR SUPPLIES | |
| | CPT/HCPCS | One CPT or HCPCS procedure code for each detail. |
| | MODIFIER | Modifier(s) when applicable. |
| E. | DIAGNOSIS POINTER | Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed. |
| F. | $ CHARGES | The full charge for the services totaled in the detail. This charge must be the usual charge to any client, patient or other beneficiary of the provider's services.<br>RCFs' charges should equal no less than the product of the number of units (days) times the beneficiary's Daily Service Rate. If the charge is less, Medicaid will pay the billed charge. |
| G. | DAYS OR UNITS | The units (in whole numbers) of service provided during the period indicated in Field 24A of the detail. |
| H. | EPSDT/Family Plan | Enter E if the services resulted from a Child Health Services (EPSDT) screening and referral. |
| I. | ID QUAL | Not required. |
| J. | RENDERING PROVIDER ID # | Not applicable. |
| | NPI | Not required. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | Name and title of the referral source. |
| 17a. (blank) | The 9-digit Arkansas Medicaid provider ID number of the referring physician when applicable. |
| 17b. NPI | Not required. |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | Not applicable. |
| 19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER | Insert LEA number. |
| 20. OUTSIDE LAB? | Not required. |
| $ CHARGES | Not required. |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Enter the applicable ICD indicator to identify which version of ICD codes is being reported.<br>Use "9" for ICD-9-CM.<br>Use "0" for ICD-10-CM.<br>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.<br>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. |
| 22. RESUBMISSION CODE | Reserved for future use. |
| ORIGINAL REF. NO. | Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy. |
| 23. PRIOR AUTHORIZATION NUMBER | The prior authorization or benefit extension control number when applicable. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | Not required when Medicaid is the only payer. |
| a. INSURED'S DATE OF BIRTH | Not required. |
| SEX | Not required. |
| b. OTHER CLAIM ID NUMBER | Not required. |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | Not required. |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d.Only one box can be marked. |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File," "SOF" or legal signature. |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File," "SOF" or legal signature. |
| 14. DATE OF CURRENT:<br>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.<br>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness ; 484 Last Menstrual Period. |
| 15. OTHER DATE | Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.<br>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:<br>454 Initial Treatment<br>304 Latest Visit or Consultation<br>453 Acute Manifestation of a Chronic Condition<br>439 Accident<br>455 Last X-Ray<br>471 Prescription<br>090 Report Start (Assumed Care Date)<br>091 Report End (Relinquished Care Date)<br>444 First Visit or Consultation |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | Not required. |

| Field Name and Number | | Instructions for Completion |
|---|---|---|
| | ZIP CODE | Five-digit ZIP code; nine digits for post office box. |
| | TELEPHONE (Include Area Code) | The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone |
| 6. | PATIENT RELATIONSHIP TO INSURED | If insurance affects this claim, check the box indicating the patient's relationship to the insured. |
| 7. | INSURED'S ADDRESS (No., Street) | Required if the insured's address is different from the patient's address. |
| | CITY | |
| | STATE | |
| | ZIP CODE | |
| | TELEPHONE (Include Area Code) | |
| 8. | RESERVED | Reserved for NUCC use. |
| 9. | OTHER INSURED'S NAME (Last name, First Name, Middle Initial) | If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial. |
| | a. OTHER INSURED'S POLICY OR GROUP NUMBER | Policy and/or group number of the insured individual. |
| | b. RESERVED | Reserved for NUCC use. |
| | SEX | Not required. |
| | c. EMPLOYER'S NAME OR SCHOOL NAME | Required when items 9a and d are required. Name of the insured individual's employer and/or school. |
| | d. INSURANCE PLAN NAME OR PROGRAM NAME | Name of the insurance company. |
| 10. | IS PATIENT'S CONDITION RELATED TO: | |
| | a. EMPLOYMENT? (Current or Previous) | Check YES or NO. |
| | b. AUTO ACCIDENT? | Required when an auto accident is related to the services. Check YES or NO. |
| | PLACE (State) | If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place. |
| | c. OTHER ACCIDENT? | Required when an accident other than automobile is related to the services. Check YES or NO. |
| | d. CLAIM CODES | The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition codes is found at www.nucc.org under Code Sets. |

A. For approved cases, an approval letter will be mailed to the requesting provider ~~and the authorizing physician~~, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.

B. For denied cases, a denial letter with reason for denial will be mailed to the beneficiary~~,~~ and the requesting provider ~~and the authorizing physician~~. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation.

**244.000 Duration of PA** ~~1-1-13~~1-1-18

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

B. ~~The contracted QIO~~ DHS professional staff or contractor(s) designated by DHS may validate a PA for one year if the provider requests an extended PA because the beneficiary ~~is an individual with~~ has a permanent disability or ~~the physician signs the service plan indicating a~~ CHRONIC CONDITION that will not improve within the next six (6) months.

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

**262.410 Completing a CMS-1500 Claim Form for Personal Care** ~~9-1-14~~1-1-18

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

| Field Name and Number | | Instructions for Completion |
|---|---|---|
| 1. | (type of coverage) | Not required. |
| 1a. | INSURED'S I.D. NUMBER (For Program in Item 1) | Beneficiary's 10-digit Medicaid or ARKids First-A identification number. |
| 2. | PATIENT'S NAME (Last Name, First Name, Middle Initial) | Beneficiary's last name and first name. |
| 3. | PATIENT'S BIRTH DATE | Beneficiary's date of birth as given on the individual's Medicaid or ARKids First-A identification card. Format: MM/DD/YY. |
| | SEX | Check M for male or F for female. |
| 4. | INSURED'S NAME (Last Name, First Name, Middle Initial) | Required if insurance affects this claim. Insured's last name, first name and middle initial. |
| 5. | PATIENT'S ADDRESS (No., Street) | Optional. Beneficiary's complete mailing address (street address or post office box). |
| | CITY | Name of the city in which the beneficiary resides. |
| | STATE | Two-letter postal code for the state in which the beneficiary resides. |

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

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

## 240.000 PRIOR AUTHORIZATION

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries, including beneficiaries participating in the IndependentChoices Program ~~under the age of 21~~.

~~B. Prior authorization does not apply to Arkansas Medicaid Personal Care Program services for beneficiaries of ages 21 and older.~~

~~C~~B. Prior authorization does not guarantee payment for the service.

1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.
2. The provider must follow the billing procedures in this manual.

### 241.000 Personal Care Program Prior Authorization (PA) Responsibility ~~7-1-15~~1-1-18

A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization of personal care services for beneficiaries. ~~The Quality Improvement Organization (QIO) contracted with Arkansas Medicaid is responsible for prior authorization of personal care services for beneficiaries under age 21. View or print AFMC contact information.~~

B. ~~The contracted QIO~~ DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's request and submitted documentation for personal care services. For approved services, ~~the QIO~~ they authorizes a set amount of service time per month (expressed in service-time increments, four per hour) and issues a prior authorization control number (PA Number) for the approved service.

C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

### 242.000 Personal Care PA Request Procedure ~~7-1-15~~1-1-18

A. Providers must use pages 1 through 6 of form DMS-618 to request PA. **View or print form DMS-618 (English). View or print form DMS-618 (Spanish).**

B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals will be retroactive to the beginning date of service if the request is received within the 30-day time frame.

C. Mail or fax the required documents to DHS professional staff or contractor(s) designated by DHS.~~the contracted Quality Improvement Organization (QIO). View or print AFMC contact information.~~

### 243.000 Provider Notification Procedure ~~10-1-08~~1-1-18

Reviews will be completed by ~~the contracted QIO~~ DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

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

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

1. The initial and all subsequent assessments.
2. Instructions to the personal care aide regarding:
   a. The tasks the aide is to perform,
   b. The frequency of each task and
   c. The maximum number of hours and minutes per month of aide service authorized by DHS professional staff or contractor(s) designated by DHS~~the beneficiary's attending physician~~.
3. Notes arising from the supervisor's visits to the service delivery location, regarding:
   a. The condition of the beneficiary,
   b. Evaluation of the aide's service performance,
   c. The beneficiary's evaluation of the aide's service performance and
   d. Difficulties the aide encounters performing any tasks.
4. The service plan and service plan revisions:
   a. The justifications for service plan revisions,
   b. Justification for emergency, unscheduled tasks and
   c. Documentation of prior or post approval of unscheduled tasks.

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

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

1. Examination results,
2. Skills test results and
3. Personal care aide certification.

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

1. The date of service,
2. The routines performed on that date of service, noted to affirm completion of each task.
3. The time of day the aide began performing the first service-plan-required task for the beneficiary;
4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;
5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks and

the beneficiary's representative, and the assessing registered nurse~~ and the beneficiary's PCP or attending physician~~. View or print form DMS-618.

2. The supervising RN's or QMRP's case documentation, as described in Section 220.100, for the ninety days preceding the new beginning date of service established in the service plan that generated the benefit extension request. This documentation is not required if the service plan is the beneficiary's initial service plan for personal care services.

3. The personal care aide's service log and documentation, as described in Sections 216.400 and 220.110 through 220.112, of the ninety days preceding the new beginning date of service established in the service plan generating the benefit extension request. This documentation is not required if the service plan is the beneficiary's initial service plan for personal care services.

B. Subsequent to a benefit extension approval, if the need arises for additional personal care service, revise the service plan and initiate the extension request process, whether or not the previously approved period of extended benefits has expired.

**217.120 Duration of Benefit Extension** ~~1-1-13~~1-1-18

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

B. When the beneficiary's diagnosis indicates a permanent disability or ~~the physician signs the service plan indicating a~~ CHRONIC CONDITION that will not improve within the next six (6) months, ~~DMS~~ DHS professional staff or contractor(s) designated by DHS may authorize services for one year. For individuals with permanent disabilities, benefit extension requests will be necessary only once every 12 months unless the service plan changes.

1. If there is a service plan revision, the provider must submit a benefit extension request for the number of hours being requested.

2. Upon approval of the requested extension, the updated benefit extension approval file is valid for 12 months from the beginning of the month in which the revised service plan takes effect.

3. If there is a service plan revision before 12 months have passed, the provider must initiate the benefit extension approval process again.

**221.000 Documentation** ~~1-1-13~~1-1-18

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

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

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

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

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

C. Medicaid contract.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.230 Dressing** ~~10-13-031~~ 1-18

A. The tasks constituting this service are those involved in hands-on assistance dressing the beneficiary or helping the beneficiary dress.

1. An aide's time spent reminding a beneficiary to dress, or to dress appropriately for a particular setting or for the weather, is not a covered aide service, unless the beneficiary's service plan requires hands-on assistance with dressing.

2. An aide's time spent observing a beneficiary dress is not a covered aide service, unless ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS certifies in the service plan, that failure to observe the beneficiary's dressing places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to clothe themselves.

C. The aide's service in regard to the beneficiary's dressing is hands-on assistance with dressing tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.240 Personal Hygiene** ~~10-13-031~~ 1-18

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's personal hygiene.

1. An aide's time spent reminding a beneficiary to perform personal hygiene tasks is not a covered service unless the beneficiary's service plan includes hands-on assistance with personal hygiene.

2. An aide's time spent observing a beneficiary perform personal hygiene tasks is not a covered service unless ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the activity places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.

C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**217.100 Benefit Extension Requests for Beneficiaries Aged 21 and Older** ~~10-13-031~~ 1-18

A. Submit to DMS:

1. A completed form DMS-618 (all pages), including the current new or revised ~~physician~~ prior authorization for personal care services, signed by the beneficiary or

**216.212 Consuming Meals** ~~10-13-031~~ 1-18

A. The service related to this routine includes the tasks involved in giving the beneficiary hands-on assistance to consume a meal.

B. To receive personal care assistance with this routine, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.

C. The related service is hands-on assistance with the beneficiary's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the beneficiary cannot physically perform, in accordance with the beneficiary's physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following examples.

1. An assessment states, "Beneficiary's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the beneficiary."

2. The same assessment also states, "Effects of a recent stroke cause the beneficiary to choke or to risk choking unless food is pureed."

a. The related task in the service plan is for the aide to "puree food items for the beneficiary."

b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the beneficiary," addresses the arthritic condition.

E. Observing a beneficiary eat is not a covered service unless ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's eating places the beneficiary at risk of injury or harm.

**216.220 Bathing** ~~10-13-031~~ 1-18

A. The tasks constituting this service are those involved in hands-on assistance with a beneficiary's bath.

1. The time spent reminding a beneficiary to bathe is covered only for a beneficiary whose service plan requires hands-on assistance to accomplish bathing.

2. Time spent observing a beneficiary bathe is not a covered service, unless ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's bathing places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to perform some or all of the tasks associated with bathing, such as:

1. Safely entering or exiting the tub or shower and washing, rinsing and towel-drying, or

2. Sponge bathing, if the beneficiary cannot safely enter or exit a tub or shower under any circumstances and cannot sponge-bathe himself or herself.

C. The aide's service in regard to the beneficiary's bathing is hands-on assistance with bathing tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

A. Each provider must create an individualized service plan and collaborate with the beneficiary's other personal care provider(s) to create a comprehensive service plan.

1. Each comprehensive service plan must clearly state which provider provides which services, where and on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week that the provider will take to perform those services.

2. Each comprehensive service plan must be authorized, signed and dated by the providerbeneficiary's primary care physician (PCP) unless the beneficiary is not required to enroll with a PCP, in which case the comprehensive service plan must be authorized, signed and dated by the beneficiary's primary attending physician.

B. Each time a personal care provider intends to revise or renew a comprehensive service plan, that provider must notify the beneficiary's other personal care provider(s) to agree on the revision or renewal and to submit the revised or renewed comprehensive plan to the authorizing physician DHS professional staff or contractor(s) designated by DHS for approval.

C. If the providers cannot agree on a comprehensive service plan, plan revision or plan renewal, the providers shall submit the various alternatives to the authorizing physician DHS professional staff or contractor(s) designated by DHS, who shall determine the terms of the final comprehensive service plan.

D. Any Medicaid provider having knowledge that another Medicaid provider has failed to comply with a service plan, including a comprehensive service plan, shall notify the DMS Director of such failure within 10 business days of the occurrence, or sooner if the beneficiary's life or health is threatened.

**216.000 Coverage** ~~1-1-13~~1-1-18

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

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State

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

3. Prior authorized by DHS professional staff or contractor(s) designated by DHSDMS or its designee when the beneficiary is under the age of 21

4. Provided by an individual who is

   a. Qualified to provide the services,

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

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

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

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

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

2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.

3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.

   a. While changes in the amount, frequency or duration of a service must be documented in the medical record, an increase or a reduction of 10% or less in the average **amount** of service (measured in service time) over a period of fewer than 30 days does not in itself require a service plan revision. If the amount of service remains unchanged, but the frequency or duration of a service is modified, documentation of the reason for the change is required, but no physician authorization is required.

   b. The reasons for the service variances must be written daily in the service documentation.

B. Providers may not reduce a beneficiary's services without ~~the physician's~~ prior authorization by DHS professional staff or contractor(s) designated by DHS ~~only by meeting the following conditions:~~

~~1. The provider must advise the physician of the reduction in services in writing, within 14 working days following the first day of reduced services.~~

~~2. The provider must request the physician's written approval of the reduction.~~

~~a. The provider is responsible for obtaining the physician's signed authorization.~~

~~b. The physician may fax the signed authorization to the provider and maintain the original in the beneficiary's file in the physician's office.~~

C. The ~~physician~~ personal care provider must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by ~~the physician~~ DHS professional staff or contractor(s) designated by DHS.

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

**215.340 Termination of Services** ~~10-13-03~~1-1-18

A. If the provider, the beneficiary, or the beneficiary's representative terminates services, the provider must advise ~~the physician~~ DHS professional staff or contractor(s) designated by DHS of the termination.

B. Notification must occur immediately and no later than 24 hours after the scheduled time for the first service canceled by the termination action.

1. Initial notification may be in person, or by telephone, e-mail, or fax.

2. The provider must also submit the notification by original signed document within five (5) working days following the initial notification.

3. Notification of Medicaid service delay or termination must occur even if the patient will continue to receive personal care services from another source.

**215.351 Service Plan Requirements for Multiple Providers** ~~10-1-07~~1-1-18

When a beneficiary receives services from more than one personal care provider, each provider must comply with the following requirements.

E. A beneficiary is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.

1. This condition causes similar physical dependency needs in different routines.

| Sample Assessment Entry | |
|---|---|
| Eating: | The beneficiary needs someone to place eating utensils in his grasp and to retrieve them when he drops them. |
| Oral hygiene: | The beneficiary needs someone to place his toothbrush in his grasp and to retrieve it when he drops it. |

2. The service plan will contain instructions to the aide similar to this Sample Service Plan Entry.

| Sample Service Plan Entry | |
|---|---|
| Eating: | Place the (*object*) in (*beneficiary's name*)'s grasp. |
| Oral hygiene: | Retrieve the (*object*) when *(beneficiary's name)* drops it and replace the (*object*) in his grasp. |

F. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the beneficiary at the individual task performance level.

1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.

2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.



## 215.320 Service Initiation and Service Initiation Delay ~~10-13-031-1-18~~

A. The provider will begin personal care services on the authorized beginning date of service.

B. If services do not begin on that date, the provider must advise the beneficiary (or the beneficiary's representative) and ~~the physician~~ DHS professional staff or contractor(s) designated by DHS of the reason for the delay.

1. The provider must furnish immediate notification in person, or by telephone, e-mail or fax, within 24 hours following the date and time that personal care services were to have begun.

2. The provider must also furnish the same individuals with a written statement, over an original authorized signature, within five (5) working days following the date personal care services were to have begun.

## 215.330 Service Plan Revisions ~~1-1-131-1-18~~

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

A. ~~The attending physician~~ DHS professional staff or contractor(s) designated by DHS must authorize permanent service plan changes before the provider amends service delivery.

1. For purposes of this requirement, a **permanent** service plan change is one expected to last 30 days or more.

1. To assist the beneficiary to perform the task,
2. To perform the task for the beneficiary or
3. To observe the beneficiary perform the task.

G. The service plan must require the beneficiary to perform all tasks within the beneficiary's capability. Medicaid does not cover assistance with any task a beneficiary can perform unless ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS have authorized ~~authorizes~~ the assistance. For example:

1. A beneficiary can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.
   a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.
   b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.
   c. The registered nurse instructs the aide to perform the task(s) constituting the service.
2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular beneficiary.
3. Removing laundry from the washer and loading it in the dryer are covered tasks for this beneficiary if those tasks are described in his service plan and authorized by ~~his physician~~ DHS professional staff or contractor(s) designated by DHS.

H. The assessment must support the service plan and the RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a beneficiary is receiving services in more than one setting, it must be clear in which setting a beneficiary receives a particular service or assistance. See part G of Section 215.200, Section 216.201 and Sections 220.110 through 220.112.

I. The provider must revise a service plan if a beneficiary's average daily service time consistently varies from the service plan's maximum or minimum estimated service time by ten percent (10%) or more over a period exceeding or expected to exceed thirty days.

1. During brief periods (less than 30 days duration) of service interruption or service-time variation, the provider must document any extenuating circumstances and explain each service plan deviation for each day of the period of service interruption or service alteration.
2. See Section 215.330 for more service plan revision requirements.

**215.310 Identifying Individual Physical Dependency Needs** ~~10-13-031~~ 1-18

A. A personal care provider must identify and describe (*assess*) a beneficiary's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living.

B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*).

C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS.

D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the beneficiary at the level of individual task performance:

as state plan personal care services. Services are effective the date of the DAAS RN's signature on the waiver assessment tool or the waiver plan of care, whichever is the latter of the two. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver plan of care must include, at least, the information included on the DMS-618 that is utilized to support the medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in documentation whether or not an extension of benefits is requested. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.

**215.300 Service Plan** ~~10-13-031~~ 1-18

A beneficiary must receive services in accordance with an individualized service plan.

A. The plan must be acceptable to the beneficiary or the beneficiary's representative.

B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the beneficiary or the beneficiary's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.

C. The individualized service plan must be limited to assistance with the beneficiary's individual physical dependency needs.

D. The service plan must clearly identify which of the beneficiary's physical dependency needs will be met by each task performed by a personal care aide.

1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the explanatory detail. For example:
   a. "Task 1 (corresponds to) Physical Dependency 2."
   b. "Task 6 (corresponds to) Physical Dependency 3."
2. In addition to establishing its correspondence to the assessment (e.g., designing individualized services for a beneficiary's physical dependency needs); the service plan must describe for each routine or activity listed:
   a. The individual tasks the aide is to perform for the beneficiary,
   b. The individual tasks with which the aide is to assist the beneficiary and
   c. The frequency and duration of service of each routine and activity, including:
      (1). The number of days per week each routine or activity will be accomplished and
      (2). The maximum and minimum estimated aggregate time the aide should spend on all authorized tasks each service day.

E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the beneficiary's routines or activities including:

1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and
2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:

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

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

**214.320 Revisions to the ARChoices Plan of Care** ~~1-1-16~~1-1-18

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

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

**215.100 Assessment and Service Plan Formats** ~~1-1-16~~1-1-18

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

1. Whether Medicaid does or does not require exclusive use of form DMS-618, all documentation required by the Personal Care Program must meet or exceed DMS regulations as stated in this manual and other official communications.
2. When using form DMS-618, attachments may be necessary to complete assessments and service plans and/or to comply with other rules.
   a. An assessing Registered Nurse (RN) must sign or initial and date each attachment he or she adds to a required personal care document.
   ~~b. The authorizing physician must sign (or initial) and date each attachment he or she adds to a service plan or other required document.~~

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

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

For IndependentChoices participants, the DMS-618 is not required. Only the AR Path assessment will be used by the DAAS RN.

For IndependentChoices participants who are also active waiver participants in the ARChoices Program, the assessment tool used for waiver level of care determination and the waiver plan of care will suffice to support authorization for personal care services, if signed by the DAAS RN. Eligibility for personal care services is based on the same criteria

1. ~~The beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS must review the service plan no less often than every six months, unless described otherwise in this section. See **NOTE** below.

2. Upon completion of the six-month review, ~~the physician~~ DHS professional staff or contractor(s) designated by DHS may authorize continued personal care services, either unchanged or with modifications~~;~~, or ~~the physician~~ may order that services cease.

B. Personal care services may not continue past the six-month anniversary of an initial or revised beginning date of service until ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS authorizes a revised service plan or renews the authorization of an existing service plan.

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

~~**NOTE: An advanced practice nurse (APN) enrolled in the Arkansas Medicaid Program seeing patients in a Rural Health Clinic or Federally Qualified Health Center enrolled in the Arkansas Medicaid Program as an RHC or FQHC may sign the personal care service plan/order if practicing within an environment for which his/her certification applies and within the scope of his/her certification. No MD signature is required in addition to the APN's signature unless required by their license and/or certification.**~~

**214.300 Authorization of ARChoices Plan of Care and Personal Care Service Plan** ~~**1-1-16**~~**1-1-18**

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

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

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

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

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

~~1. The date services are to begin (may not be earlier than the date of the physician's signature.)~~

~~2. The duration of need for services~~

~~3. The expected results of the services~~

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

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

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

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

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

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

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

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

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

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

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

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

### 214.200 Service Plan Review and Renewal ~~1-1-13~~ 1-1-18

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

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

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

1. The physician evaluates the relationships among the beneficiary's health status, physical dependency needs and daily routines and activities.

2. The physician helps the beneficiary and the personal care provider design an individualized plan to address the beneficiary's individual physical dependencies.

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

1. The beneficiary's attending physician is responsible for the decision to authorize personal care services.

2. The beneficiary's attending physician must be the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP requirements.

a. In this manual, "physician" and "attending physician" both mean "the physician primarily responsible for the medical management of the patient," unless they are otherwise defined in a particular context.

b. "Primary care physician" and "PCP" are explained in Section I of this manual.

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

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

1. The attending physician and the beneficiary must have a face-to-face visit before the physician may authorize personal care services, unless the physician has seen the beneficiary within the 60 days preceding the beginning date of service established in the proposed service plan or 60 days prior to the date the physician signs the DMS-618.

2. The attending physician must review the assessment and service plan to ensure that the personal care aide's assigned tasks appropriately address the beneficiary's individual physical dependency needs.

3. Based on the assessment and the physician's medical evaluation, the attending physician must authorize only individualized personal care services that constitute medically necessary assistance with the beneficiary's physical dependency needs in the beneficiary's home or other authorized locations rather than in an institution.

shopping for personal care items and transportation to stores to shop for personal care items, but it is included in the 64-hour per month personal care benefit limit for beneficiaries aged 21 and older.

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

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

**213.600 In-State and Out-of-State Limited Services Secondary Personal Care Providers** ~~3-1-11~~ 1-1-18

On rare occasions, a personal care beneficiary might have urgent cause to travel to a locality outside his or her personal care provider's service area. If ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay in that locality, the beneficiary may choose a personal care provider agency in the service area to which he or she is traveling.

A. In-State and Out-of-State Limited Services Secondary Personal Care Provider

If the selected provider is an in-state provider, the selected provider's services may be covered if all the following requirements are met:

1. The beneficiary's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the beneficiary's service for the specified duration of the beneficiary's stay.
2. The primary provider must forward to the secondary provider a copy of the beneficiary's current service plan and service documentation, including logs, for a minimum service period of sixty days prior to the request.
3. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.
4. The secondary provider must execute a written agreement to assume the beneficiary's care on behalf of the primary provider.
5. The secondary provider must submit its service documentation to the primary provider within ten working days of the beneficiary's departure from the temporary locality.

B. Out-of-State Limited Services Secondary Personal Care Provider

If the provider is an out-of-state provider, the provider must also download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).**

The selected provider must also submit to the Division of Medical Services, Utilization Review Section, a written request for prior authorization accompanied with copies of the provider's license, Medicare certification, beneficiary's identifying information and the beneficiary's service plan. **View or print Division of Medical Services, Utilization Review Section contact information**.

C. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.

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

2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.

3. The need for individual assistance indicates whether to consider personal care.

**213.540 Employment-related Personal Care Outside the Home** ~~7-15-12~~1-1-18

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

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

1. The beneficiary must have an authorized, individualized personal care service plan that includes the covered personal care services necessary to and appropriate for an employed individual or for an individual seeking employment.

2. The beneficiary must be aged 16 or older.

3. The beneficiary's disability must meet the Social Security/SSI disability definition.

a A beneficiary's disability may be confirmed by verifying his or her eligibility for SSI, Social Security disability benefits or a Medicaid disability aid category, such as Working Disabled or DDS Alternative Community Services waiver.

b. If uncertain whether a beneficiary qualifies under this disability provision, contact the Department of Human Services local office in the county in which the beneficiary resides.

4. One of the following two conditions must be met.

a. The beneficiary must work at least 40 hours per month in an integrated setting (i.e., a workplace that is not a sheltered workshop and where individuals without disabilities are employed or are eligible for employment on parity with applicants with a disability).

b. Alternatively, the beneficiary must be actively seeking employment that requires a minimum of 40 hours of work per month in an integrated setting.

5. The beneficiary must earn at least minimum wage or be actively seeking employment that pays at least minimum wage.

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

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

1. Aides may assist beneficiaries with transportation to and from work or job-seeking and *during* transportation to and from work or for job-seeking.

2. All employment-related services, including those associated with transportation, must be included in detail (i.e., at the individual task performance level; see Section 215.300, part F) in the service plan and all pertinent service documentation.

3. Medicaid does not cover mileage associated with any personal care service.

4. Authorized, necessary and documented assistance with transportation to and from work for job-seeking and during transportation to and from work or for job-seeking is neither subject to nor included in the eight-hour per month benefit limit that applies to

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

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

F. Only Class-A Home Health agencies, Class-B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, education service cooperatives and DDS facilities may provide personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

**213.200 Physical Dependency Need Criteria for Service Eligibility** ~~7-22-101~~ 1-18

A. The terms "routines," "activities of daily living" and "service" have particular definitions that apply to the Personal Care Program. See Sections 216.100 through 216.140 for definitions of these and other terms employed in this manual.

B. Personal care services, described in Sections 216.000 through 216.330, must be medically necessary services authorized by ~~a beneficiary's attending physician~~ DHS professional staff or contractor(s) designated by DHS.

C. Personal care services are individually designed to assist with a beneficiary's physical dependency needs related to the following routine activities of daily living and instrumental activities of daily living:

1. Bathing
2. Bladder and bowel requirements
3. Dressing
4. Eating
5. Incidental housekeeping
6. Laundry
7. Personal hygiene
8. Shopping for personal maintenance items
9. Taking medications*
10. Mobility and Ambulation

* Assistance with medications is a personal care service only to the extent that the Arkansas Nurse Practice Act and implementing regulations permit a personal care aide to perform the service.

D. A number of conditions may cause "physical dependency needs."

1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.

B. Out-of-state providers not licensed in Arkansas may participate in Arkansas Medicaid only as limited services providers.

C. Out-of-state providers not licensed in Arkansas may become limited services providers under two sets of circumstances.

1. A provider not licensed in Arkansas may become an Arkansas Medicaid limited services provider after the provider has provided services to an Arkansas Medicaid eligible beneficiary and the provider has a claim or claims to file with Arkansas Medicaid.

2. A provider not licensed in Arkansas may become an Arkansas Medicaid "secondary" limited services provider when a beneficiary has a need to travel out-of-state, ~~and the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay out-of-state, and the beneficiary chooses the personal care provider agency in the out-of-state service area to which he or she is traveling.

**212.000 Program Purpose** ~~10-13-031-~~ 1-18

A. The purpose of Personal Care Program services is to supplement, not to supplant, other resources available to the beneficiary.

B. Personal care services are medically necessary services authorized by ~~an attending physician~~ DHS professional staff or contractor(s) designated by DHS and individually designed to assist beneficiaries with their physical dependency needs as described in Section 213.200 and Sections 216.100 through 216.140.

**213.000 Scope of the Program** ~~1-1-16~~1-1-18

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

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

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

1. Home health aides may provide personal care services in the home under the home health benefit.

2. Skilled services that only a health professional may perform are not considered personal care services.

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

F. The aide's service in the beneficiary's meal preparation routine is hands-on assistance with meal preparation tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

G. Simultaneous services to two beneficiaries or to more than two beneficiaries in a congregate setting may be covered if the rules below and the regulations stated at Section 216.201 and Sections 220.110 through 220.112 are followed.

1. Medicaid will cover the actual time attributable to the individual beneficiary when services, such as meal preparation, are delivered simultaneously.

2. Refer to Section 220.111 for the methodologies required to determine the amount of time attributable to the individual beneficiary.

H. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following example.

1. A beneficiary is able to remove items from the refrigerator and pantry and to perform most tasks related to meal preparation.

2. The assessment states, "Beneficiary's arthritic condition prevents him from opening bottles and jars with small tops and from gripping eating utensils."

3. A related entry in the service plan would be similar to:

Meal preparation:

a. The aide will open bottles and jars with lids too small for the beneficiary to negotiate.

b. The aide will operate cooking and serving utensils the beneficiary cannot grip or pick up.

I. The complete meal-preparation routine might include additional instructions. These examples are simply to illustrate that instructions at the task level facilitate correlation of physical dependency needs with individualized services.

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

1. The date of service,

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

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

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

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

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

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

**202.200 Personal Care Providers Not Licensed in Arkansas** ~~3-1-11~~1-1-18

A. In-state providers not licensed in Arkansas may not provide personal care services in Arkansas.

*TOC required*

## 200.000 PERSONAL CARE GENERAL INFORMATION

### 200.100 Arkansas Medicaid Participation Requirements for Personal Care Providers

~~8-1-04~~1-1-18

Numerous agencies, organizations and other entities may qualify for enrollment in the Arkansas Medicaid Personal Care Program. Participation requirements vary among these different types of providers. Sections 200.110 through 200.160 outline the participation requirements specific to each type of personal care provider. Section 201.000 describes the procedures required to enroll in the Medicaid Program. Sections 201.010 through 201.050 set forth the licensing, certification and other requirements specific to each type of personal care provider.

All owners, principals, employees, and contract staff of a personal care provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

### 200.130 Private Care Agencies

~~1-1-16~~1-1-18

A. A private care agency applying to enroll as a personal care provider must be licensed by the Arkansas Department of Health.

~~B. Private care agencies must hold current licensure from the Arkansas Department of Labor.~~

~~C~~B. Private care agencies must be enrolled in the Arkansas Medicaid ARChoices Program.

~~D~~C. Private care agencies must have liability insurance coverage of not less than one million dollars ($1,000,000.00) covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

### 201.120 Private Care Agencies

~~3-1-05~~1-1-18

A. Private care agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current license from the Arkansas Department of Health.

~~B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit a copy of their current license from the Arkansas Department of Labor.~~

~~C~~B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit proof of liability insurance coverage of not less than one million dollars ($1,000,000.00), covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

~~D~~C. Annually, private care agency providers must ensure that there is on file with the Provider Enrollment Unit proof that the agency's required liability insurance remains in force and has remained in force at a level of coverage no less than the required minimum since the provider's previous report.

D. This routine includes the tasks involved in:

1. Preparing and serving a meal and
2. Cleaning articles and utensils used in the preparation of the meal.

E. To be eligible to receive personal care assistance with meal preparation, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to perform meal-preparation tasks or to clean up the utensils and preparation area.

| Field Name and Number | Instructions for Completion |
|---|---|
| 32. SERVICE FACILITY LOCATION INFORMATION | If services were not performed at the beneficiary's home or at the provider's facility (*e.g.*, school, DDS facility etc.) enter the name, street address, city, state and zip code of the facility, workplace etc. where services were performed. If services were furnished at multiple sites (for instance, when job-seeking), indicate "multiple locations" or leave blank. |
| a. (blank) | Not required. |
| b. (blank) | Not required. |
| 33. BILLING PROVIDER INFO & PH # | Billing provider's name and complete address. Telephone number is requested but not required. |
| a. (blank) | Not required. |
| b. (blank) | Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider. |

| Field Name and Number | Instructions for Completion |
|---|---|
| F. $ CHARGES | The full charge for the services totaled in the detail. This charge must be the usual charge to any client, patient or other beneficiary of the provider's services.<br><br>RCFs' charges should equal no less than the product of the number of units (days) times the beneficiary's Daily Service Rate. If the charge is less, Medicaid will pay the billed charge. |
| G. DAYS OR UNITS | The units (in whole numbers) of service provided during the period indicated in Field 24A of the detail. |
| H. EPSDT/Family Plan | Enter E if the services resulted from a Child Health Services (EPSDT) screening and referral. |
| I. ID QUAL | Not required. |
| J. RENDERING PROVIDER ID # | Not applicable. |
| NPI | Not required. |
| 25. FEDERAL TAX I.D. NUMBER | Not required. This information is carried in the provider's Medicaid file. If it changes, advise Provider Enrollment so that the year-end 1099 will be correct and reported correctly. |
| 26. PATIENT'S ACCOUNT NO. | Optional entry for providers' accounting and account-retrieval purposes. Enter up to 16 numeric, alphabetic or alpha-numeric characters. This character set appears on the Remittance Advice as "MRN." |
| 27. ACCEPT ASSIGNMENT? | Not required. Assignment is automatically accepted by the provider when billing Medicaid. |
| 28. TOTAL CHARGE | Total of Column 24F—the sum of all charges on the claim. |
| 29. AMOUNT PAID | Enter the total of payments received from other sources on this claim. Do not include amounts previously paid by Medicaid. |
| 30. RESERVED | Reserved for NUCC use. |
| 31. SIGNATURE OF PROVIDER | The performing provider or an individual authorized by the performing provider or by an institutional, corporate, business or other provider organization, must sign and date the claim, certifying that the services were furnished by the provider, under (when applicable) the direction of the individual provider or other qualified individual, and in strict and verifiable accordance with all applicable rules of the Medicaid program in which the provider participates. A "provider's signature" is the provider's or authorized individual's personally written signature, a rubber stamp of the signature, an automated signature or a typed signature. The name of a group practice, a facility or institution, a corporation, a business or any other organization will prevent the claim from being processed. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 22. RESUBMISSION CODE | Reserved for future use. |
| ORIGINAL REF. NO. | Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy. |
| 23. PRIOR AUTHORIZATION NUMBER | The prior authorization or benefit extension control number when applicable. |
| 24A. DATE(S) OF SERVICE | The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.<br>1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.<br>2. A provider may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the date sequence.<br>3. RCFs may bill for a date span of any length within the same calendar month, provided the beneficiary was present every day of the date span and all services provided within the date span were at the same Level of Care. |
| B. PLACE OF SERVICE | Two-digit national standard place of service code. |
| C. EMG | Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency. |
| D. PROCEDURES, SERVICES, OR SUPPLIES | |
| CPT/HCPCS | One CPT or HCPCS procedure code for each detail. |
| MODIFIER | Modifier(s) when applicable. |
| E. DIAGNOSIS POINTER | Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed. |

| Field Name and Number | Instructions for Completion |
|---|---|
| 15. OTHER DATE | Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.<br>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:<br>454 Initial Treatment<br>304 Latest Visit or Consultation<br>453 Acute Manifestation of a Chronic Condition<br>439 Accident<br>455 Last X-Ray<br>471 Prescription<br>090 Report Start (Assumed Care Date)<br>091 Report End (Relinquished Care Date)<br>444 First Visit or Consultation |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | Not required. |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | Name and title of the referral source. |
| 17a. (blank) | The 9-digit Arkansas Medicaid provider ID number of the referring physician when applicable. |
| 17b. NPI | Not required. |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | Not applicable. |
| 19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER | Insert LEA number. |
| 20. OUTSIDE LAB? | Not required. |
| $ CHARGES | Not required. |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY | Enter the applicable ICD indicator to identify which version of ICD codes is being reported.<br>Use "9" for ICD-9-CM.<br>Use "0" for ICD-10-CM.<br>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.<br>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. |

| Field Name and Number | Instructions for Completion |
|---|---|
| c. OTHER ACCIDENT? | Required when an accident other than automobile is related to the services. Check YES or NO. |
| d. CLAIM CODES | The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition codes is found at www.nucc.org under Code Sets. |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | Not required when Medicaid is the only payer. |
| a. INSURED'S DATE OF BIRTH | Not required. |
| SEX | Not required. |
| b. OTHER CLAIM ID NUMBER | Not required. |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | Not required. |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? | When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d.Only one box can be marked. |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File," "SOF" or legal signature. |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE | Enter "Signature on File," "SOF" or legal signature. |
| 14. DATE OF CURRENT:<br>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) | Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.<br><br>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness ; 484 Last Menstrual Period. |

| Field Name and Number | | Instructions for Completion |
|---|---|---|
| 4. | INSURED'S NAME (Last Name, First Name, Middle Initial) | Required if insurance affects this claim. Insured's last name, first name and middle initial. |
| 5. | PATIENT'S ADDRESS (No., Street) | Optional. Beneficiary's complete mailing address (street address or post office box). |
| | CITY | Name of the city in which the beneficiary resides. |
| | STATE | Two-letter postal code for the state in which the beneficiary resides. |
| | ZIP CODE | Five-digit ZIP code; nine digits for post office box. |
| | TELEPHONE (Include Area Code) | The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone |
| 6. | PATIENT RELATIONSHIP TO INSURED | If insurance affects this claim, check the box indicating the patient's relationship to the insured. |
| 7. | INSURED'S ADDRESS (No., Street) | Required if the insured's address is different from the patient's address. |
| | CITY | |
| | STATE | |
| | ZIP CODE | |
| | TELEPHONE (Include Area Code) | |
| 8. | RESERVED | Reserved for NUCC use. |
| 9. | OTHER INSURED'S NAME (Last name, First Name, Middle Initial) | If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial. |
| | a. OTHER INSURED'S POLICY OR GROUP NUMBER | Policy and/or group number of the insured individual. |
| | b. RESERVED | Reserved for NUCC use. |
| | SEX | Not required. |
| | c. EMPLOYER'S NAME OR SCHOOL NAME | Required when items 9a and d are required. Name of the insured individual's employer and/or school. |
| | d. INSURANCE PLAN NAME OR PROGRAM NAME | Name of the insurance company. |
| 10. | IS PATIENT'S CONDITION RELATED TO: | |
| | a. EMPLOYMENT? (Current or Previous) | Check YES or NO. |
| | b. AUTO ACCIDENT? | Required when an auto accident is related to the services. Check YES or NO. |
| | PLACE (State) | If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place. |

B. Requests for prior authorization must be submitted within thirty calendar days of the start of care. Approvals will be retroactive to the beginning date of service if the request is received within the 30-day time frame.

C. Mail or fax the required documents to DHS professional staff or contractor(s) designated by DHS.

**243.000 Provider Notification Procedure** **1-1-18**

Reviews will be completed by DHS professional staff or contractor(s) designated by DHS within fifteen (15) working days of receipt of a complete PA request.

A. For approved cases, an approval letter will be mailed to the requesting provider, detailing the procedure codes approved, total number of service time increments, beginning and ending dates and the authorization number.

B. For denied cases, a denial letter with reason for denial will be mailed to the beneficiary and the requesting provider. Reconsideration of the denial may be requested within thirty calendar days of the denial date. Requests for reconsideration must be made in writing and include additional documentation.

**244.000 Duration of PA** **1-1-18**

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

B. DHS professional staff or contractor(s) designated by DHS may validate a PA for one year if the provider requests an extended PA because the beneficiary has a permanent disability or a CHRONIC CONDITION that will not improve within the next six (6) months.

1. A one-year PA remains valid only if the service plan and services remain unchanged and the provider meets all Personal Care Program requirements.

2. Providers receiving extended PAs for individuals with a permanent disability must continue to follow Personal Care Program policy regarding regular assessments and service plan renewals and revisions.

**262.410 Completing a CMS-1500 Claim Form for Personal Care** **1-1-18**

When a provider must bill on a paper claim, the fiscal agent accepts only red-lined, sensor-coded CMS-1500 claim forms. Claim photocopies and claim forms that are not sensor-coded cannot be processed.

| Field Name and Number | | Instructions for Completion |
|---|---|---|
| 1. | (type of coverage) | Not required. |
| 1a. | INSURED'S I.D. NUMBER (For Program in Item 1) | Beneficiary's 10-digit Medicaid or ARKids First-A identification number. |
| 2. | PATIENT'S NAME (Last Name, First Name, Middle Initial) | Beneficiary's last name and first name. |
| 3. | PATIENT'S BIRTH DATE | Beneficiary's date of birth as given on the individual's Medicaid or ARKids First-A identification card. Format: MM/DD/YY. |
| | SEX | Check M for male or F for female. |

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

1. Examination results,
2. Skills test results and
3. Personal care aide certification.

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

1. The date of service,
2. The routines performed on that date of service, noted to affirm completion of each task.
3. The time of day the aide began performing the first service-plan-required task for the beneficiary;
4. The time of day the aide stopped performing any service-plan-required task to perform any non-service-plan-required function;
5. The time of day the aide stopped performing any non-service-plan-required function to resume service-plan-required tasks and
6. The time of day the aide completed the last service-plan-required task for the day for that beneficiary.

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

## 240.000 PRIOR AUTHORIZATION 1-1-18

A. The Arkansas Medicaid Personal Care Program requires prior authorization of services in the home and other locations for all beneficiaries, including beneficiaries participating in the IndependentChoices Program.

B. Prior authorization does not guarantee payment for the service.

1. The beneficiary must be Medicaid-eligible on the dates of service and must have available benefits.
2. The provider must follow the billing procedures in this manual.

### 241.000 Personal Care Program Prior Authorization (PA) Responsibility 1-1-18

A. DHS professional staff or contractor(s) designated by DHS are responsible for prior authorization of personal care services for beneficiaries. B. DHS professional staff or contractor(s) designated by DHS reviews the personal care provider's request and submitted documentation for personal care services. For approved services, they authorize a set amount of service time per month (expressed in service-time increments, four per hour) and issue a prior authorization control number (PA Number) for the approved service.

C. DHS professional staff or contractor(s) designated by DHS have a right to review the beneficiary's medical information.

### 242.000 Personal Care PA Request Procedure 1-1-18

A. Providers must use pages 1 through 6 of form DMS-618 to request PA. **View or print form DMS-618 (English). View or print form DMS-618 (Spanish).**

3. If there is a service plan revision before 12 months have passed, the provider must initiate the benefit extension approval process again.

**221.000 Documentation** **1-1-18**

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

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

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

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

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

C. Medicaid contract.

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

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

1. The initial and all subsequent assessments.
2. Instructions to the personal care aide regarding:
   a. The tasks the aide is to perform,
   b. The frequency of each task and
   c. The maximum number of hours and minutes per month of aide service authorized by DHS professional staff or contractor(s) designated by DHS.
3. Notes arising from the supervisor's visits to the service delivery location, regarding:
   a. The condition of the beneficiary,
   b. Evaluation of the aide's service performance,
   c. The beneficiary's evaluation of the aide's service performance and
   d. Difficulties the aide encounters performing any tasks.
4. The service plan and service plan revisions:
   a. The justifications for service plan revisions,
   b. Justification for emergency, unscheduled tasks and
   c. Documentation of prior or post approval of unscheduled tasks.

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

1. An aide's time spent reminding a beneficiary to perform personal hygiene tasks is not a covered service unless the beneficiary's service plan includes hands-on assistance with personal hygiene.

2. An aide's time spent observing a beneficiary perform personal hygiene tasks is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the activity places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency preventing or substantially impairing their ability to perform hair and skin care and grooming, oral hygiene, shaving and nail care.

C. The aide's service in regard to this routine is hands-on assistance with personal hygiene tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**217.100 Benefit Extension Requests for Beneficiaries Aged 21 and Older** 1-1-18

A. Submit to DMS:

1. A completed form DMS-618 (all pages), including the current new or revised prior authorization for personal care services, signed by the beneficiary or the beneficiary's representative, and the assessing registered nurse. View or print form DMS-618.

2. The supervising RN's or QMRP's case documentation, as described in Section 220.100, for the ninety days preceding the new beginning date of service established in the service plan that generated the benefit extension request. This documentation is not required if the service plan is the beneficiary's initial service plan for personal care services.

3. The personal care aide's service log and documentation, as described in Sections 216.400 and 220.110 through 220.112, of the ninety days preceding the new beginning date of service established in the service plan generating the benefit extension request. This documentation is not required if the service plan is the beneficiary's initial service plan for personal care services.

B. Subsequent to a benefit extension approval, if the need arises for additional personal care service, revise the service plan and initiate the extension request process, whether or not the previously approved period of extended benefits has expired.

**217.120 Duration of Benefit Extension** 1-1-18

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

B. When the beneficiary's diagnosis indicates a permanent disability or a CHRONIC CONDITION that will not improve within the next six (6) months, DHS professional staff or contractor(s) designated by DHS may authorize services for one year. For individuals with permanent disabilities, benefit extension requests will be necessary only once every 12 months unless the service plan changes.

1. If there is a service plan revision, the provider must submit a benefit extension request for the number of hours being requested.

2. Upon approval of the requested extension, the updated benefit extension approval file is valid for 12 months from the beginning of the month in which the revised service plan takes effect.

E. Observing a beneficiary eat is not a covered service unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's eating places the beneficiary at risk of injury or harm.

**216.220 Bathing** 1-1-18

A. The tasks constituting this service are those involved in hands-on assistance with a beneficiary's bath.

1. The time spent reminding a beneficiary to bathe is covered only for a beneficiary whose service plan requires hands-on assistance to accomplish bathing.
2. Time spent observing a beneficiary bathe is not a covered service, unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan that failure to observe the beneficiary's bathing places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to perform some or all of the tasks associated with bathing, such as:

1. Safely entering or exiting the tub or shower and washing, rinsing and towel-drying, or
2. Sponge bathing, if the beneficiary cannot safely enter or exit a tub or shower under any circumstances and cannot sponge-bathe himself or herself.

C. The aide's service in regard to the beneficiary's bathing is hands-on assistance with bathing tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.230 Dressing** 1-1-18

A. The tasks constituting this service are those involved in hands-on assistance dressing the beneficiary or helping the beneficiary dress.

1. An aide's time spent reminding a beneficiary to dress, or to dress appropriately for a particular setting or for the weather, is not a covered aide service, unless the beneficiary's service plan requires hands-on assistance with dressing.
2. An aide's time spent observing a beneficiary dress is not a covered aide service, unless DHS professional staff or contractor(s) designated by DHS certifies in the service plan, that failure to observe the beneficiary's dressing places the beneficiary at risk of injury or harm.

B. Beneficiaries eligible for this service must have a physical dependency need preventing or substantially impairing their ability to clothe themselves.

C. The aide's service in regard to the beneficiary's dressing is hands-on assistance with dressing tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310.

**216.240 Personal Hygiene** 1-1-18

A. The tasks constituting this service are those involved in hands-on assistance with the beneficiary's personal hygiene.

**216.000 Coverage** 1-1-18

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

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State
2. Provided by an individual qualified to provide such services and who is not a member of the beneficiary's family. See Section 222.100, part A, for the definition of "a member of the beneficiary's family"
3. Prior authorized by DHS professional staff or contractor(s) designated by DHS
4. Provided by an individual who is
   a. Qualified to provide the services,
   b. Supervised by a registered nurse (RN) or (when applicable) a Qualified Mental Retardation Professional (QMRP) and
   c. Not a member of the beneficiary's family OR
   d. Qualified to provide the service according to approved policy in the IndependentChoices Program.
5. Furnished in the beneficiary's home or, at the State's option, in another location

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

**216.212 Consuming Meals** 1-1-18

A. The service related to this routine includes the tasks involved in giving the beneficiary hands-on assistance to consume a meal.

B. To receive personal care assistance with this routine, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to execute tasks such as cutting food in bite-size pieces or negotiating food from plate to mouth.

C. The related service is hands-on assistance with the beneficiary's physical dependency needs to accomplish eating. The aide may only assist with or perform functional tasks the beneficiary cannot physically perform, in accordance with the beneficiary's physical dependency needs described in the assessment.

D. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following examples.

1. An assessment states, "Beneficiary's arthritis prevents him from gripping slender objects such as eating utensils with either hand." The related task in the service plan is for the aide to "cut items into bite-size pieces and deliver them from plate to mouth for the beneficiary."
2. The same assessment also states, "Effects of a recent stroke cause the beneficiary to choke or to risk choking unless food is pureed."
   a. The related task in the service plan is for the aide to "puree food items for the beneficiary."
   b. A separate statement, "The aide will deliver spoonfuls from plate to mouth for the beneficiary," addresses the arthritic condition.

documentation.

B. Providers may not reduce a beneficiary's services without prior authorization by DHS professional staff or contractor(s) designated by DHS

C. The personal care provider must document medical reasons for service plan revisions.

D. The new beginning date of service is the date authorized by DHS professional staff or contractor(s) designated by DHS.

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

**215.340 Termination of Services** **1-1-18**

A. If the provider, the beneficiary, or the beneficiary's representative terminates services, the provider must advise DHS professional staff or contractor(s) designated by DHS of the termination.

B. Notification must occur immediately and no later than 24 hours after the scheduled time for the first service canceled by the termination action.

1. Initial notification may be in person, or by telephone, e-mail, or fax.
2. The provider must also submit the notification by original signed document within five (5) working days following the initial notification.
3. Notification of Medicaid service delay or termination must occur even if the patient will continue to receive personal care services from another source.

**215.351 Service Plan Requirements for Multiple Providers** **1-1-18**

When a beneficiary receives services from more than one personal care provider, each provider must comply with the following requirements.

A. Each provider must create an individualized service plan and collaborate with the beneficiary's other personal care provider(s) to create a comprehensive service plan.

1. Each comprehensive service plan must clearly state which provider provides which services, where and on which day(s) they do so, which time(s) of day they furnish services and the maximum and minimum amount of time per day and per week that the provider will take to perform those services.
2. Each comprehensive service plan must be authorized, signed and dated by the provider.

B. Each time a personal care provider intends to revise or renew a comprehensive service plan, that provider must notify the beneficiary's other personal care provider(s) to agree on the revision or renewal and to submit the revised or renewed comprehensive plan to DHS professional staff or contractor(s) designated by DHS for approval.

C. If the providers cannot agree on a comprehensive service plan, plan revision or plan renewal, the providers shall submit the various alternatives to DHS professional staff or contractor(s) designated by DHS, who shall determine the terms of the final comprehensive service plan.

D. Any Medicaid provider having knowledge that another Medicaid provider has failed to comply with a service plan, including a comprehensive service plan, shall notify the DMS Director of such failure within 10 business days of the occurrence, or sooner if the beneficiary's life or health is threatened.

2. The service plan will contain instructions to the aide similar to this Sample Service Plan Entry.

| **Sample Service Plan Entry** | |
|---|---|
| Eating: | Place the (*object*) in (*beneficiary's name*)'s grasp. |
| Oral hygiene: | Retrieve the (*object*) when *(beneficiary's name)* drops it and replace the (*object*) in his grasp. |

F. Medicaid Program staff reviewing a personal care provider's records must be able to readily observe that the service plan logically follows the assessment, which is possible only if the provider assesses the beneficiary at the individual task performance level.

1. Additionally, the aide's daily service documentation and the registered nurse's case notes must address the requirements and objectives of the service plan.

2. There must be a clear and logical relationship of each component of this documentation to each other component and to the service continuum.

**215.320 Service Initiation and Service Initiation Delay** **1-1-18**

A. The provider will begin personal care services on the authorized beginning date of service.

B. If services do not begin on that date, the provider must advise the beneficiary (or the beneficiary's representative) and DHS professional staff or contractor(s) designated by DHS of the reason for the delay.

1. The provider must furnish immediate notification in person, or by telephone, e-mail or fax, within 24 hours following the date and time that personal care services were to have begun.

2. The provider must also furnish the same individuals with a written statement, over an original authorized signature, within five (5) working days following the date personal care services were to have begun.

**215.330 Service Plan Revisions** **1-1-18**

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

A. DHS professional staff or contractor(s) designated by DHS must authorize permanent service plan changes before the provider amends service delivery.

1. For purposes of this requirement, a **permanent** service plan change is one expected to last 30 days or more.

2. Service plan revisions must be made if a beneficiary's condition changes to the extent that the personal care provider must modify, add or delete tasks.

3. Service plan revisions must be made if the provider identifies a need to increase or decrease the amount, frequency or duration of service.

a. While changes in the amount, frequency or duration of a service must be documented in the medical record, an increase or a reduction of 10% or less in the average **amount** of service (measured in service time) over a period of fewer than 30 days does not in itself require a service plan revision. If the amount of service remains unchanged, but the frequency or duration of a service is modified, documentation of the reason for the change is required, but no physician authorization is required.

b. The reasons for the service variances must be written daily in the service

a. The assessment notes that he needs assistance with the task of removing wet items from the washing machine.

b. The service plan describes the assistance designed for his individual physical dependency need with his laundry.

c. The registered nurse instructs the aide to perform the task(s) constituting the service.

2. Loading the washer, emptying the dryer, folding and ironing clothing and linens are not covered tasks for this particular beneficiary.

3. Removing laundry from the washer and loading it in the dryer are covered tasks for this beneficiary if those tasks are described in his service plan and authorized by DHS professional staff or contractor(s) designated by DHS.

H. The assessment must support the service plan and the RN's instructions to the aide(s) regarding the delivery of services. The plan must reflect whether the individual is receiving services in more than one setting. If a beneficiary is receiving services in more than one setting, it must be clear in which setting a beneficiary receives a particular service or assistance. See part G of Section 215.200, Section 216.201 and Sections 220.110 through 220.112.

I. The provider must revise a service plan if a beneficiary's average daily service time consistently varies from the service plan's maximum or minimum estimated service time by ten percent (10%) or more over a period exceeding or expected to exceed thirty days.

1. During brief periods (less than 30 days duration) of service interruption or service-time variation, the provider must document any extenuating circumstances and explain each service plan deviation for each day of the period of service interruption or service alteration.

2. See Section 215.330 for more service plan revision requirements.

**215.310 Identifying Individual Physical Dependency Needs** **1-1-18**

A. A personal care provider must identify and describe (*assess*) a beneficiary's need for assistance (*physical dependency need*) with individual task components of routines and activities of daily living.

B. The provider must describe the type, amount, frequency and duration of assistance required for each task thus identified (*individualized service plan*).

C. A personal care aide furnishes assistance (*service*) with the individual task components of routines and activities of daily living, in accordance with the individualized service plan authorized by DHS professional staff or contractor(s) designated by DHS.

D. The following examples illustrate how to facilitate service plan development and service documentation by assessing the beneficiary at the level of individual task performance:

E. A beneficiary is unable to pick up slender items, such as spoons and toothbrushes, and sometimes loses his grip on those objects.

1. This condition causes similar physical dependency needs in different routines.

| Sample Assessment Entry | |
|---|---|
| Eating: | The beneficiary needs someone to place eating utensils in his grasp and to retrieve them when he drops them. |
| Oral hygiene: | The beneficiary needs someone to place his toothbrush in his grasp and to retrieve it when he drops it. |

**215.300 Service Plan** **1-1-18**

A beneficiary must receive services in accordance with an individualized service plan.

A. The plan must be acceptable to the beneficiary or the beneficiary's representative.

B. A registered nurse and other appropriate personnel of the personal care provider agency, in concert with the beneficiary or the beneficiary's representative, must design the individualized service plan to correlate with the physical dependency needs identified in the assessment.

C. The individualized service plan must be limited to assistance with the beneficiary's individual physical dependency needs.

D. The service plan must clearly identify which of the beneficiary's physical dependency needs will be met by each task performed by a personal care aide.

1. This requirement does not necessarily mandate writing a unique statement for each task or task component. Indexing the assessment may expedite documentation by permitting one to reference the relevant section of the assessment for the explanatory detail. For example:
   a. "Task 1 (corresponds to) Physical Dependency 2."
   b. "Task 6 (corresponds to) Physical Dependency 3."
2. In addition to establishing its correspondence to the assessment (e.g., designing individualized services for a beneficiary's physical dependency needs); the service plan must describe for each routine or activity listed:
   a. The individual tasks the aide is to perform for the beneficiary,
   b. The individual tasks with which the aide is to assist the beneficiary and
   c. The frequency and duration of service of each routine and activity, including:
      (1). The number of days per week each routine or activity will be accomplished and
      (2). The maximum and minimum estimated aggregate time the aide should spend on all authorized tasks each service day.

E. The service plan must include written instructions for the personal care aide specifying how and when to execute or assist with the beneficiary's routines or activities including:

1. The number of days per week to accomplish each routine or activity (as well as which days when relevant) and
2. The time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

F. The service plan must include written instructions describing whether and to what extent the aide's function in individual task components of each routine or activity is:

1. To assist the beneficiary to perform the task,
2. To perform the task for the beneficiary or
3. To observe the beneficiary perform the task.

G. The service plan must require the beneficiary to perform all tasks within the beneficiary's capability. Medicaid does not cover assistance with any task a beneficiary can perform unless DHS professional staff or contractor(s) designated by DHS have authorized the assistance. For example:

1. A beneficiary can manage his own laundry but he cannot extract wet items from the washer while leaning over the machine.

### 214.320 Revisions to the ARChoices Plan of Care 1-1-18

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

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

### 215.100 Assessment and Service Plan Formats 1-1-18

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

1. Whether Medicaid does or does not require exclusive use of form DMS-618, all documentation required by the Personal Care Program must meet or exceed DMS regulations as stated in this manual and other official communications.
2. When using form DMS-618, attachments may be necessary to complete assessments and service plans and/or to comply with other rules.
    a. An assessing Registered Nurse (RN) must sign or initial and date each attachment he or she adds to a required personal care document.

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

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

For IndependentChoices participants, the DMS-618 is not required. Only the AR Path assessment will be used by the DAAS RN.

For IndependentChoices participants who are also active waiver participants in the ARChoices Program, the assessment tool used for waiver level of care determination and the waiver plan of care will suffice to support authorization for personal care services, if signed by the DAAS RN. Eligibility for personal care services is based on the same criteria as state plan personal care services. Services are effective the date of the DAAS RN's signature on the waiver assessment tool or the waiver plan of care, whichever is the latter of the two. Personal care services provided prior to that date are not eligible for Medicaid reimbursement. The waiver assessment tool and the waiver plan of care must include, at least, the information included on the DMS-618 that is utilized to support the medical necessity, eligibility and amount of personal care services provided through IndependentChoices or agency personal care services. This information is required in documentation whether or not an extension of benefits is requested. As with all required documentation, this information must be available in the participant's chart or electronic record and available for audit and Quality Management Strategy reviews.

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

1. DHS professional staff or contractor(s) designated by DHS must review the service plan no less often than every six months, unless described otherwise in this section. See **NOTE** below.

2. Upon completion of the six-month review, DHS professional staff or contractor(s) designated by DHS may authorize continued personal care services, either unchanged or with modifications, or may order that services cease.

B. Personal care services may not continue past the six-month anniversary of an initial or revised beginning date of service until DHS professional staff or contractor(s) designated by DHS authorizes a revised service plan or renews the authorization of an existing service plan.

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



### 214.300 Authorization of ARChoices Plan of Care and Personal Care Service Plan 1-1-18

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

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

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

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

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

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

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

**213.600 In-State and Out-of-State Limited Services Secondary Personal Care Providers** 1-1-18

On rare occasions, a personal care beneficiary might have urgent cause to travel to a locality outside his or her personal care provider's service area. If DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay in that locality, the beneficiary may choose a personal care provider agency in the service area to which he or she is traveling.

A. In-State and Out-of-State Limited Services Secondary Personal Care Provider

If the selected provider is an in-state provider, the selected provider's services may be covered if all the following requirements are met:

1. The beneficiary's personal care provider (the "primary" provider) must request in writing that the selected provider (the "secondary" provider) assume the beneficiary's service for the specified duration of the beneficiary's stay.
2. The primary provider must forward to the secondary provider a copy of the beneficiary's current service plan and service documentation, including logs, for a minimum service-period of sixty days prior to the request.
3. If the secondary provider requests additional information or documentation, the primary provider must forward the requested materials immediately.
4. The secondary provider must execute a written agreement to assume the beneficiary's care on behalf of the primary provider.
5. The secondary provider must submit its service documentation to the primary provider within ten working days of the beneficiary's departure from the temporary locality.

B. Out-of-State Limited Services Secondary Personal Care Provider

If the provider is an out-of-state provider, the provider must also download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).**

The selected provider must also submit to the Division of Medical Services, Utilization Review Section, a written request for prior authorization accompanied with copies of the provider's license, Medicare certification, beneficiary's identifying information and the beneficiary's service plan. **View or print Division of Medical Services, Utilization Review Section contact information**.

C. All documentation exchanged between the primary and secondary providers must satisfy all Medicaid requirements.



**214.200 Service Plan Review and Renewal** 1-1-18

## 213.540 Employment-related Personal Care Outside the Home 1-1-18

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

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

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

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

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

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

D. All personal care for beneficiaries requires prior authorization.

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

E. Personal care for Medicaid-eligible individuals requires prior authorization. See Sections 240.000 through 246.000.

F. Only Class-A Home Health agencies, Class-B Home Health agencies and Private Care agencies may provide personal care in all State-approved locations. Residential care facilities, public schools, education service cooperatives and DDS facilities may provide personal care only within their own facilities. School districts and education service cooperatives may not provide personal care in the beneficiary's home unless the home is deemed a public school in accordance with the Arkansas Department of Education guidelines set forth in Section 213.520.

**213.200 Physical Dependency Need Criteria for Service Eligibility** **1-1-18**

A. The terms "routines," "activities of daily living" and "service" have particular definitions that apply to the Personal Care Program. See Sections 216.100 through 216.140 for definitions of these and other terms employed in this manual.

B. Personal care services, described in Sections 216.000 through 216.330, must be medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS.

C. Personal care services are individually designed to assist with a beneficiary's physical dependency needs related to the following routine activities of daily living and instrumental activities of daily living:

1. Bathing
2. Bladder and bowel requirements
3. Dressing
4. Eating
5. Incidental housekeeping
6. Laundry
7. Personal hygiene
8. Shopping for personal maintenance items
9. Taking medications*
10. Mobility and Ambulation

* Assistance with medications is a personal care service only to the extent that the Arkansas Nurse Practice Act and implementing regulations permit a personal care aide to perform the service.

D. A number of conditions may cause "physical dependency needs."

1. Particular disabilities or conditions may or may not be pertinent to specific needs for individual assistance.
2. In assessing an individual's need for personal care, the question to pursue is whether the individual is unable to perform tasks covered by this program without assistance from someone else.
3. The need for individual assistance indicates whether to consider personal care.

1. A provider not licensed in Arkansas may become an Arkansas Medicaid limited services provider after the provider has provided services to an Arkansas Medicaid eligible beneficiary and the provider has a claim or claims to file with Arkansas Medicaid.
2. A provider not licensed in Arkansas may become an Arkansas Medicaid "secondary" limited services provider when a beneficiary has a need to travel out-of-state, DHS professional staff or contractor(s) designated by DHS authorizes personal care during the beneficiary's stay out-of-state, and the beneficiary chooses the personal care provider agency in the out-of-state service area to which he or she is traveling.

**212.000 Program Purpose 1-1-18**

A. The purpose of Personal Care Program services is to supplement, not to supplant, other resources available to the beneficiary.

B. Personal care services are medically necessary services authorized by DHS professional staff or contractor(s) designated by DHS and individually designed to assist beneficiaries with their physical dependency needs as described in Section 213.200 and Sections 216.100 through 216.140.

**213.000 Scope of the Program 1-1-18**

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

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

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

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

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

1. Authorized for the individual by DHS professional staff or contractor(s) designated by DHS in accordance with a service plan approved by the State, e.g., ARChoices, IndependentChoices;
2. Furnished in the beneficiary's home, and at the State's option, in another location.

G. Simultaneous services to two beneficiaries or to more than two beneficiaries in a congregate setting may be covered if the rules below and the regulations stated at Section 216.201 and Sections 220.110 through 220.112 are followed.

1. Medicaid will cover the actual time attributable to the individual beneficiary when services, such as meal preparation, are delivered simultaneously.

2. Refer to Section 220.111 for the methodologies required to determine the amount of time attributable to the individual beneficiary.

H. The service plan must correlate each required task with its corresponding physical dependency need. See Sections 215.300 and 215.310 and the following example.

1. A beneficiary is able to remove items from the refrigerator and pantry and to perform most tasks related to meal preparation.

2. The assessment states, "Beneficiary's arthritic condition prevents him from opening bottles and jars with small tops and from gripping eating utensils."

3. A related entry in the service plan would be similar to:

Meal preparation:

a. The aide will open bottles and jars with lids too small for the beneficiary to negotiate.

b. The aide will operate cooking and serving utensils the beneficiary cannot grip or pick up.

I. The complete meal-preparation routine might include additional instructions. These examples are simply to illustrate that instructions at the task level facilitate correlation of physical dependency needs with individualized services.

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

1. The date of service;

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

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

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

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

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

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

## 202.200 Personal Care Providers Not Licensed in Arkansas 1-1-18

A. In-state providers not licensed in Arkansas may not provide personal care services in Arkansas.

B. Out-of-state providers not licensed in Arkansas may participate in Arkansas Medicaid only as limited services providers.

C. Out-of-state providers not licensed in Arkansas may become limited services providers under two sets of circumstances.

*TOC required*

## 200.000 PERSONAL CARE GENERAL INFORMATION

### 200.100 Arkansas Medicaid Participation Requirements for Personal Care Providers 1-1-18

Numerous agencies, organizations and other entities may qualify for enrollment in the Arkansas Medicaid Personal Care Program. Participation requirements vary among these different types of providers. Sections 200.110 through 200.160 outline the participation requirements specific to each type of personal care provider. Section 201.000 describes the procedures required to enroll in the Medicaid Program. Sections 201.010 through 201.050 set forth the licensing, certification and other requirements specific to each type of personal care provider.

All owners, principals, employees, and contract staff of a personal care provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

### 200.130 Private Care Agencies 1-1-18

A. A private care agency applying to enroll as a personal care provider must be licensed by the Arkansas Department of Health.

B. Private care agencies must be enrolled in the Arkansas Medicaid ARChoices Program.

C. Private care agencies must have liability insurance coverage of not less than one million dollars ($1,000,000.00) covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

### 201.120 Private Care Agencies 1-1-18

A. Private care agencies must ensure that there is on file with the Medicaid Provider Enrollment Unit a copy of their current license from the Arkansas Department of Health.

B. Private care agencies must ensure that there is on file with the Provider Enrollment Unit proof of liability insurance coverage of not less than one million dollars ($1,000,000.00), covering their employees and independent contractors while those individuals and entities are engaged in providing covered Medicaid services.

C. Annually, private care agency providers must ensure that there is on file with the Provider Enrollment Unit proof that the agency's required liability insurance remains in force and has remained in force at a level of coverage no less than the required minimum since the provider's previous report.

D. This routine includes the tasks involved in:

1. Preparing and serving a meal and
2. Cleaning articles and utensils used in the preparation of the meal.

E. To be eligible to receive personal care assistance with meal preparation, a beneficiary's physical dependency needs must prevent or substantially impair his or her ability to perform meal-preparation tasks or to clean up the utensils and preparation area.

F. The aide's service in the beneficiary's meal preparation routine is hands-on assistance with meal preparation tasks the beneficiary cannot physically perform, according to the detailed physical dependency needs described in the assessment.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

**Division of Medical Services**
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**TO:** **Arkansas Medicaid Health Care Providers – Private Duty Nursing Services**

**EFFECTIVE DATE:** **January 1, 2018**

**SUBJECT:** **Provider Manual Update Transmittal PDN-1-17**

| **REMOVE** | | **INSERT** | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 201.100 | 11-1-09 | 201.100 | 1-1-18 |

**Explanation of Updates**

Section 201.100 is updated to include a background check requirement for private duty nursing services.

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 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*

**201.100 Private Duty Nursing Services Providers 1-1-18**

Private Duty Nursing Services (PDN) 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. The PDN provider must have either a Class A or Class B license issued by the Arkansas Division of Health. It must be designated on the license that the PDN agency is a provider of extended care services.

1. A copy of the license must accompany the provider application and Medicaid contract.

2. For purposes of review under the Arkansas Medicaid Program, agencies enrolled as Class B operators providing private duty nursing services must adhere to those standards governing quality of care, skill and expertise applicable to Class A operators.

Providers who have agreements with Medicaid to provide other services to Medicaid beneficiaries must have a separate provider application and Medicaid contract to provide private duty nursing services. A separate provider number is assigned.

B. All owners, principals, employees, and contract staff of a private duty nursing services provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

*TOC not required*

**201.100 Private Duty Nursing Services Providers** ~~11-1-09~~1-1-18

Private Duty Nursing Services (PDN) 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. The PDN provider must have either a Class A or Class B license issued by the Arkansas Division of Health. It must be designated on the license that the PDN agency is a provider of extended care services.

1. A copy of the license must accompany the provider application and Medicaid contract.

2. For purposes of review under the Arkansas Medicaid Program, agencies enrolled as Class B operators providing private duty nursing services must adhere to those standards governing quality of care, skill and expertise applicable to Class A operators.

Providers who have agreements with Medicaid to provide other services to Medicaid beneficiaries must have a separate provider application and Medicaid contract to provide private duty nursing services. A separate provider number is assigned.

B. All owners, principals, employees, and contract staff of a private duty nursing services provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

**EFFECTIVE DATE:** January 1, 2018

**SUBJECT:** Provider Manual Update Transmittal RURLHLTH-1-17

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 213.000 | 1-1-16 | 213.000 | 1-1-18 |

**Explanation of Updates**

Section 213.000 is updated to include the independent assessment requirement for personal care services.

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 Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.



Dawn Stehle
Director

*TOC not required*

**213.000 Staff Requirements and Responsibilities** **1-1-18**

A. The RHC must have a health care staff that includes one or more physicians and one or more physician assistants or nurse practitioners. The physicians, physician assistants or nurse practitioners may be the owners of the RHC and/or under agreement with the RHC to carry out the responsibilities required.

B. The staff may include ancillary personnel who are supervised by the professional staff.

C. A physician, physician assistant or nurse practitioner must be available to furnish patient care services at times the RHC operates. These staff must be available to furnish patient care services at least 50% of the time the RHC operates.

D. The physician must provide medical direction for the RHC activities and consultation for the medical supervision of the health care staff. The physician also must participate in developing, executing and periodically reviewing policies, services, patient records and must provide medical orders and medical care services to patients of the RHC.

E. The physician assistant and nurse practitioner, as members of the RHC staff, must participate in the development, execution and periodic review of the written policies governing the services the RHC furnishes and participate with the physician in a periodic review of patients' health records.

F. The physician assistant or nurse practitioner must perform the following functions, to the extent they are not being performed by a physician:

1. Provide services in accordance with RHC policies;
2. Arrange for or refer patient for services that cannot be provided by the RHC; and
3. Assure adequate patient health records are maintained and transferred as required when patients are referred.
4. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information.

*TOC not required*

**213.000 Staff Requirements and Responsibilities** ~~1-1-16~~1-1-18

A. The RHC must have a health care staff that includes one or more physicians and one or more physician assistants or nurse practitioners. The physicians, physician assistants or nurse practitioners may be the owners of the RHC and/or under agreement with the RHC to carry out the responsibilities required.

B. The staff may include ancillary personnel who are supervised by the professional staff.

C. A physician, physician assistant or nurse practitioner must be available to furnish patient care services at times the RHC operates. These staff must be available to furnish patient care services at least 50% of the time the RHC operates.

D. The physician must provide medical direction for the RHC activities and consultation for the medical supervision of the health care staff. The physician also must participate in developing, executing and periodically reviewing policies, services, patient records and must provide medical orders and medical care services to patients of the RHC.

E. The physician assistant and nurse practitioner, as members of the RHC staff, must participate in the development, execution and periodic review of the written policies governing the services the RHC furnishes and participate with the physician in a periodic review of patients' health records.

F. The physician assistant or nurse practitioner must perform the following functions, to the extent they are not being performed by a physician:

1. Provide services in accordance with RHC policies;
2. Arrange for or refer patient for services that cannot be provided by the RHC; and
3. Assure adequate patient health records are maintained and transferred as required when patients are referred.
4. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

**EFFECTIVE DATE:** **January 1, 2018**

**SUBJECT:** **Provider Manual Update Transmittal PHYSICN-3-17**

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 203.100 | 10-13-03 | 203.100 | 1-1-18 |

**Explanation of Updates**

Section 203.100 is updated to include the independent assessment requirement for personal care services.

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 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.

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Thank you for your participation in the Arkansas Medicaid Program.



Dawn Stehle
Director

*TOC not required*

**203.100 Introduction** **1-1-18**

The Arkansas Medicaid Program depends upon the participation and cooperation of Arkansas physicians for access to most categories of health care.

Most Medicaid covered services require a physician's prescription and/or certification that a service is medically necessary. Arkansas' physicians are active partners with Medicaid in the prudent use of the State's Medicaid dollars for excellent and consistent medical care. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

Mark up



TOC not required

## 203.100 Introduction

~~10-13-03~~1-1-18

The Arkansas Medicaid Program depends upon the participation and cooperation of Arkansas physicians for access to most categories of health care.

Most Medicaid covered services require a physician's prescription and/or certification that a service is medically necessary. Arkansas' physicians are active partners with Medicaid in the prudent use of the State's Medicaid dollars for excellent and consistent medical care. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

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

**EFFECTIVE DATE:** January 1, 2018

**SUBJECT:** Provider Manual Update Transmittal INCHOICE-1-17

| REMOVE | | INSERT | |
|---|---|---|---|
| **Section** | **Effective Date** | **Section** | **Effective Date** |
| 202.300 | 1-1-16 | 202.300 | 1-1-18 |
| 202.500 | 1-1-13 | 202.500 | 1-1-18 |
| 231.200 | 4-1-08 | 231.200 | 1-1-18 |
| 231.600 | 1-1-16 | 231.600 | 1-1-18 |
| 260.420 | 11-1-09 | 260.420 | 1-1-18 |

**Explanation of Updates**

Section 202.300 has been updated with new beneficiary enrollment information.

Section 202.500 has been updated with new information regarding personal assistant services.

Section 231.200 has been updated with new requirements for IndependentChoices Services during temporary absences from the home or workplace.

Section 231.600 has been updated with new requirements for Involuntary Disenrollment.

Section 260.420 has been updated with new background check requirements for Personal Assistants.

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 Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

*TOC not required*

**202.300 Enrollment** **1-1-18**

The Division of Aging and Adult Services (DAAS) is the point of entry for all enrollment activity for IndependentChoices. The program is limited based on an approved number through the Medicaid State Plan.

The individual or their designee will first call the IndependentChoices toll-free number at 888-682-0044 or 866-710-0456. Information about the program is provided to the individual and verification made that the individual is currently enrolled in a Medicaid category that covers personal assistance services. If the individual is currently enrolled in an appropriate Medicaid category and has an assessed physical dependency need for "hands on" assistance with personal care needs, DAAS will enter the participant's information into a DAAS database. If the individual is not currently enrolled in an appropriate Medicaid category, the individual will be referred to the DHS County Office for eligibility determination.

The IndependentChoices counselor, nurse and fiscal agent will then work with the individual to complete the enrollment forms either by mail and telephone contact or by a face-to-face meeting. The individual will be provided with a program manual, which explains the individual's responsibilities regarding enrollment and continuing participation. The individual must complete the forms in the Enrollment Packet, which consists of the Participant Responsibilities and Agreement, the Backup Personal Assistant and the Authorization to Disclose Health Information. The individual must also complete the forms in the Employer Packet, which includes the Limited Power of Attorney, IRS and direct deposit forms related to being a household employer. Each personal assistant must complete the forms in the Employee Packet which include the standard tax withholding forms normally completed by an employee, the Employment Eligibility Verification Form (I-9), a Participant/Personal Assistant Agreement, Employment Application and a Provider Agreement. Each packet includes step-by-step instructions on how to complete the above forms. Assistance is available to the individual, Decision-Making Partner/Communications Manager and the personal assistant to help complete the forms and answer any questions.

As part of the enrollment process, the DAAS RN will complete an assessment using the Home and Community Based Services (HCBS) Level of Care Assessment Tool. The DAAS RN will determine, through the completed assessment and professional judgment, the level of medical necessity. This determination creates the budget for self-directed services. Eligibility for personal care services is based on the same criteria as state plan personal care services. **NOTE:** For ARChoices beneficiaries, the DAAS RN will determine the need for personal care and attendant care hours needed. The ARChoices plan of care will reflect that the beneficiary chooses IndependentChoices as the provider. DAAS-HCBS staff will obtain authorization from DHS professional staff or contractor(s) designated by DHS for persons not receiving ARChoices waiver services.

After the in-home assessment, the DAAS RN will complete the paperwork and coordinate with the IndependentChoices counselor. The counselor will process all of the completed enrollment forms. The assessment is sent to DHS professional staff or contractor(s) designated by DHS for authorization if the beneficiary is not authorized for services through a waiver plan of care for ARChoices. State and IRS tax forms will be retained by the fiscal agent. Disbursement of funds to a beneficiary or their employee will not occur until all required forms are accurately completed and in the possession of the fiscal agent.

Personal care assessments for beneficiaries aged 21 years or older and authorized DHS professional staff or contractor(s) designated by DHS in excess of 14.75 hours per week are forwarded to DAAS for coordination with Utilization Review in the Division of Medical Services for approval. **View or print Utilization Review contact information.** For beneficiaries under age 21, all personal care hours must be authorized through Medicaid's contracted Quality Improvement Organization (QIO). **View or print AFMC contact information.**

IndependentChoices follows the rules and regulations found in the Arkansas Medicaid Personal Care Provider Manual in determining and authorizing personal care hours. For beneficiaries receiving services through the ARChoices waiver program, the signature of the DAAS RN is sufficient to authorize personal care services. After the service plan is authorized, the actual day services begin is dependent upon all of the following conditions:

A. DAAS issues a seven-day notice to discontinue service to any agency personal care, ARChoices provider currently providing services to the individual.

B. The date the beneficiary's worker is able to begin providing the necessary care. It can be no earlier than the date DHS professional staff or contractor(s) designated by DHS authorized the service plan for the non-waiver eligible participant, if an agency provider is not providing the personal care services.

C. The fiscal agent is in possession of all required employer and employee documents.

If the beneficiary is not also a beneficiary of ARChoices services, then continuation of personal assistance services requires reauthorization prior to the end of the current service plan end date.

When the approval by Utilization Review is received, or the beneficiary needs 14.75 hours or less per week, the IndependentChoices Counselor will contact the beneficiary or Decision-Making Partner/Communications Manager to develop the cash expenditure plan. The Medicaid beneficiary as the employer and the counselor will determine when IndependentChoices services can begin, but may not commence prior to the date authorized by DHS professional staff or contractor(s) designated by DHS.

**202.500 Personal Assistance Services Plan** **1-1-18**

All personal assistant services must be prior authorized in accordance with the procedures in the Personal Care Provider Manual.

**231.200 Temporary Absences from the Home or Workplace** **1-1-18**

IndependentChoices services are designed to be provided in the home or workplace of the participant. Services may be provided outside the participant's home or workplace if DHS professional staff or contractor(s) designated by DHS authorizes the services during a trip or vacation.

**231.600 Involuntary Disenrollment** **1-1-18**

Participants may be disenrolled for the following reasons:

A. **Health, Safety and Well-being**: At any time that DAAS determines that the health, safety and well-being of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program.

B. **Change in Condition**: Should the participant's cognitive ability to direct his or her own care diminish to a point where he or she can no longer direct his or her own care and there is no Decision-Making Partner available to direct the care, the IndependentChoices case will be closed. The counselor will assist the participant with a referral to traditional services.

C. **Misuse of Allowance**: Should a participant or the Decision-Making Partner who is performing all of their payroll functions (and not using the fiscal agent) use the allowance to purchase items unrelated to personal care needs, fail to pay the salary of an assistant, misrepresent payment of an assistant's salary, or fail to pay related state and federal payroll taxes, the participant or Decision-Making Partner will receive a warning notice that such exceptions to the conditions of participation are not allowed. The participant will be

permitted to remain on the program, but will be assigned to the fiscal intermediary, who will provide maximum bookkeeping services. The participant or Decision-Making Partner will be notified that further failure to follow the expenditure plan could result in disenrollment. Should an unapproved expenditure or oversight occur a second time, the participant or Decision-Making Partner will be notified that the IndependentChoices case is being closed and they are being returned to traditional personal assistance services. The Office of Medicaid Inspector General is informed of situations as required. The counselor will assist the participant with transition to traditional services. The preceding rules are also applicable to participants using the fiscal agent.

D. **Underutilization of Allowance**: The fiscal agent is responsible for monitoring the use of the Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using it according to the cash expenditure plan, the fiscal agent will inform the counseling entities through quarterly reports and monthly reports on request. The counselor will discuss problems that are occurring with the participant and their support network. The counselor will continue to monitor the participant's use of their allowance through both review of reports and personal contact with the participant. If underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADL's even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days after disenrollment. Funds accrued in the absence of a savings plan will be returned to Medicaid within a twelve-month filing deadline. Involuntary disenrollment may be considered if the participant has been hospitalized for more than 30 days and a discharge date is unknown to the participant or Decision-Making Partner. Participants with approval by DHS professional staff or contractor(s) designated by DHS for an out-of-state visit may be involuntarily disenrolled if their stay extends past the approval period. The participant is required to provide a copy of authorizations by DHS professional staff or contractor(s) designated by DHS to their counselor for monitoring purposes.

E. **Failure to Assume Employer Authority**: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Disenrollment will not occur without guidance and counseling by the counselor or by the fiscal intermediary. When this occurs, the counselor will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the counselor, ask the counselor to coordinate or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

Whenever a participant is involuntarily disenrolled, the IndependentChoices program will mail a notice to close the case. The notice will provide at least 10 days but no more than 30 days before IndependentChoices will be discontinued, depending on the situation. During the transition period, the counselor will work with the participant or Decision-Making Partner to provide services to help the individual transition to the most appropriate services available

### 260.420 Employer Authority 1-1-18

The IndependentChoices participant is the employer of record, and as such, hires a Personal Assistant who meets these requirements:

A. Is a US citizen or legal alien with approval to work in the US

B. Has a valid Social Security number

C. Signs a Work Agreement with the participant/Decision-Making Partner

D. Must be able to provide references if requested

E. Submit to a criminal background check prior to employment and every three years thereafter, identity verification, and fingerprinting.

F. Obtains a Health Services card from the Division of Health. if requested

G. May not be an individual who is considered legally responsible for the client, e.g., spouse or guardian

H. Must be 18 years of age or older

I. Must be able to perform the essential job functions required

*TOC not required*

202.300 **Enrollment** ~~1-1-161-1-~~ 18

The Division of Aging and Adult Services (DAAS) is the point of entry for all enrollment activity for IndependentChoices. The program is limited based on an approved number through the Medicaid State Plan.

The individual or their designee will first call the IndependentChoices toll-free number at 888-682-0044 or 866-710-0456. Information about the program is provided to the individual and verification made that the individual is currently enrolled in a Medicaid category that covers personal assistance services. If the individual is currently enrolled in an appropriate Medicaid category and has an assessed physical dependency need for "hands on" assistance with personal care needs, DAAS will enter the participant's information into a DAAS database. If the individual is not currently enrolled in an appropriate Medicaid category, the individual will be referred to the DHS County Office for eligibility determination.

The IndependentChoices counselor, nurse and fiscal agent will then work with the individual to complete the enrollment forms either by mail and telephone contact or by a face-to-face meeting. The individual will be provided with a program manual, which explains the individual's responsibilities regarding enrollment and continuing participation. The individual must complete the forms in the Enrollment Packet, which consists of the Participant Responsibilities and Agreement, the Backup Personal Assistant and the Authorization to Disclose Health Information. The individual must also complete the forms in the Employer Packet, which includes the Limited Power of Attorney, IRS and direct deposit forms related to being a household employer. Each personal assistant must complete the forms in the Employee Packet which include the standard tax withholding forms normally completed by an employee, the Employment Eligibility Verification Form (I-9), a Participant/Personal Assistant Agreement, Employment Application and a Provider Agreement. Each packet includes step-by-step instructions on how to complete the above forms. Assistance is available to the individual, Decision-Making Partner/Communications Manager and the personal assistant to help complete the forms and answer any questions.

As part of the enrollment process, the DAAS RN will complete an assessment using the Home and Community Based Services (HCBS) Level of Care Assessment Tool. The DAAS RN will determine, through the completed assessment and professional judgment, the level of medical necessity. This determination creates the budget for self-directed services. Eligibility for personal care services is based on the same criteria as state plan personal care services. **NOTE:** For ARChoices beneficiaries, the DAAS RN will determine the need for personal care and attendant care hours needed. The ARChoices plan of care will reflect that the beneficiary chooses IndependentChoices as the provider. DAAS-HCBS staff will obtain ~~physician~~ authorization from DHS professional staff or contractor(s) designated by DHS for persons not receiving ARChoices waiver services.

After the in-home assessment, the DAAS RN will complete the paperwork and coordinate with the IndependentChoices counselor. The counselor will process all of the completed enrollment forms. The assessment is sent to ~~the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS for authorization if the beneficiary is not authorized for services through a waiver plan of care for ARChoices. State and IRS tax forms will be retained by the fiscal agent. Disbursement of funds to a beneficiary or their employee will not occur until all required forms are accurately completed and in the possession of the fiscal agent.

Personal care assessments for beneficiaries aged 21 years or older and authorized ~~by the beneficiary's physician~~ DHS professional staff or contractor(s) designated by DHS in excess of 14.75 hours per week are forwarded to DAAS for coordination with Utilization Review in the Division of Medical Services for approval. **View or print Utilization Review contact information.** For beneficiaries under age 21, all personal care hours must be authorized

through Medicaid's contracted Quality Improvement Organization (QIO). **View or print AFMC contact information.**

IndependentChoices follows the rules and regulations found in the Arkansas Medicaid Personal Care Provider Manual in determining and authorizing personal care hours. ~~The initial authorization for personal assistance services may not begin until the beneficiary's primary care physician or an advanced practice nurse enrolled in the Arkansas Medicaid APN program seeing patients in an Arkansas Medicaid enrolled Rural Health Clinic or Federally Qualified Health Center signs and dates the Home and Community Based Services (HCBS) Level of Care Assessment Tool.~~ For beneficiaries receiving services through the ARChoices waiver program, ~~the APN or physician's signature is not required. The~~ the signature of the DAAS RN is sufficient to authorize personal care services. After the service plan is authorized, the actual day services begin is dependent upon all of the following conditions:

A. DAAS issues a seven-day notice to discontinue service to any agency personal care, ARChoices provider currently providing services to the individual.

B. The date the beneficiary's worker is able to begin providing the necessary care. It can be no earlier than the date ~~the physician~~ DHS professional staff or contractor(s) designated by DHS authorized the service plan for the non-waiver eligible participant, if an agency provider is not providing the personal care services.

C. The fiscal agent is in possession of all required employer and employee documents.

If the beneficiary is not also a beneficiary of ARChoices services, then continuation of personal assistance services requires reauthorization prior to the end of the current service plan end date.

~~When required for non-waiver beneficiaries, the earlier of the two following conditions will suffice for the face-to-face visit required sixty days prior to the begin date of the new service plan:~~

~~A. The beneficiary's primary care physician or eligible nurse practitioner (as described in this manual) signature on the HCBS Level of Care Assessment Tool attests that he or she has examined the patient within the past 60 days.~~

~~B. The beneficiary has a face-to-face visit with their primary care physician or eligible nurse practitioner 60 days prior to the service plan begin date.~~

When the approval by Utilization Review is received, or the beneficiary needs 14.75 hours or less per week, the IndependentChoices Counselor will contact the beneficiary or Decision-Making Partner/Communications Manager to develop the cash expenditure plan. The Medicaid beneficiary as the employer and the counselor will determine when IndependentChoices services can begin, but may not commence prior to the date authorized by DHS professional staff or contractor(s) designated by DHS.~~the physician. The beneficiary is required to have a face-to-face visit with their physician within 60 days of the date that the physician signs the Assessment Tool or 60 days prior to the service plan begin date and each subsequent reassessment. At no time will services begin prior to the first day of the previous month unless authorized by the Division of Aging and Adult Services.~~

**202.500 Personal Assistance Services Plan** ~~1-1-131-1-18~~

~~An individualized personal assistance service plan, signed and dated by the participant's personal physician constitutes the physician's personal assistant services authorization. All services must be prior approved through the service plan.~~All personal assistant services must be prior authorized in accordance with the procedures in the Personal Care Provider Manual.

~~**NOTE: An advanced practice nurse (APN) enrolled in the Arkansas Medicaid Program seeing patients in a Rural Health Clinic or Federally Qualified Health Center enrolled in the Arkansas Medicaid Program as an RHC or FQHC may sign the personal care service plan/order if practicing within an**~~

~~environment for which his/her certification applies and within the scope of his/her certification. No MD signature is required in addition to the APN's signature unless required by their license and/or certification.~~

**231.200 Temporary Absences from the Home or Workplace** ~~4-1-081-1-~~ **18**

IndependentChoices services are designed to be provided in the home or workplace of the participant. Services may be provided outside the participant's home or workplace if ~~the participant's physician~~ DHS professional staff or contractor(s) designated by DHS authorizes the services during a trip or vacation.

**231.600 Involuntary Disenrollment** ~~4-1-161-1-~~ **18**

Participants may be disenrolled for the following reasons:

A. **Health, Safety and Well-being**: At any time that DAAS determines that the health, safety and well-being of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program.

B. **Change in Condition**: Should the participant's cognitive ability to direct his or her own care diminish to a point where he or she can no longer direct his or her own care and there is no Decision-Making Partner available to direct the care, the IndependentChoices case will be closed. The counselor will assist the participant with a referral to traditional services.

C. **Misuse of Allowance**: Should a participant or the Decision-Making Partner who is performing all of their payroll functions (and not using the fiscal agent) use the allowance to purchase items unrelated to personal care needs, fail to pay the salary of an assistant, misrepresent payment of an assistant's salary, or fail to pay related state and federal payroll taxes, the participant or Decision-Making Partner will receive a warning notice that such exceptions to the conditions of participation are not allowed. The participant will be permitted to remain on the program, but will be assigned to the fiscal intermediary, who will provide maximum bookkeeping services. The participant or Decision-Making Partner will be notified that further failure to follow the expenditure plan could result in disenrollment. Should an unapproved expenditure or oversight occur a second time, the participant or Decision-Making Partner will be notified that the IndependentChoices case is being closed and they are being returned to traditional personal assistance services. The Office of Medicaid Inspector General is informed of situations as required. The counselor will assist the participant with transition to traditional services. The preceding rules are also applicable to participants using the fiscal agent.

D. **Underutilization of Allowance**: The fiscal agent is responsible for monitoring the use of the Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using it according to the cash expenditure plan, the fiscal agent will inform the counseling entities through quarterly reports and monthly reports on request. The counselor will discuss problems that are occurring with the participant and their support network. The counselor will continue to monitor the participant's use of their allowance through both review of reports and personal contact with the participant. If underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADL's even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days after disenrollment. Funds accrued in the absence of a savings plan will be returned to Medicaid within a twelve-month filing deadline. Involuntary disenrollment may be considered if the participant has been hospitalized for more than 30 days and a discharge date is unknown to the participant or Decision-Making Partner. Participants with approval by ~~their physician~~ DHS professional staff or contractor(s) designated by DHS for an out-of-

state visit may be involuntarily disenrolled if their stay extends past the approval period ~~authorized by their physician~~. The participant is required to provide a copy of ~~the physician's~~ authorizations by DHS professional staff or contractor(s) designated by DHS to their counselor for monitoring purposes.

E. **Failure to Assume Employer Authority**: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Disenrollment will not occur without guidance and counseling by the counselor or by the fiscal intermediary. When this occurs, the counselor will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the counselor, ask the counselor to coordinate or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

Whenever a participant is involuntarily disenrolled, the IndependentChoices program will mail a notice to close the case. The notice will provide at least 10 days but no more than 30 days before IndependentChoices will be discontinued, depending on the situation. During the transition period, the counselor will work with the participant or Decision-Making Partner to provide services to help the individual transition to the most appropriate services available

**260.420 Employer Authority** ~~11-1-091-1-~~ **18**

The IndependentChoices participant is the employer of record, and as such, hires a Personal Assistant who meets these requirements:

A. Is a US citizen or legal alien with approval to work in the US

B. Has a valid Social Security number

C. Signs a Work Agreement with the participant/Decision-Making Partner

D. Must be able to provide references if requested

E. Submit to a criminal background check prior to employment and every three years thereafter, identity verification, and fingerprinting.~~if requested. If requested, DAAS will process the request for the criminal background check.~~

F. Obtains a Health Services card from the Division of Health. if requested

G. May not be an individual who is considered legally responsible for the client, e.g., spouse or guardian

H. Must be 18 years of age or older

I. Must be able to perform the essential job functions required