

ARKANSAS REGISTER

Transmittal Sheet

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



Secretary of State

John Thurston

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Little Rock, Arkansas 72201-1094

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www.sos.arkansas.gov



For Office

Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Mac E. Golden E-mail Mac.E.Golden@dhs.arkansas.gov Phone 501.320.6383

Statutory Authority for Promulgating Rules Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: Electronic Visit Verification (EVV) for Home Health Services

Intended Effective Date
(Check One)

☐ Emergency (ACA 25-15-204)

☐ 10 Days After Filing (ACA 25-15-204)

☒ Other January 01, 2024
(Must be more than 10 days after filing date.)

Legal Notice Published

Final Date for Public Comment

Reviewed by Legislative Council

Adopted by State Agency

Date

9/22/2023

10/21/2023

12/15/2023

01/01/2024

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

Lisa Teague

Lisa.Teague@dhs.arkansas.gov

12/15/2023

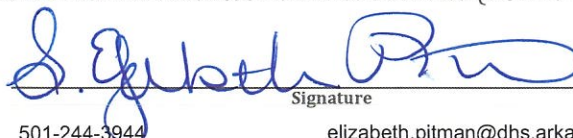
Contact Person

E-mail Address

Date

CERTIFICATION OF AUTHORIZED OFFICER

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



Signature

501-244-3944

elizabeth.pitman@dhs.arkansas.gov

Phone Number

E-mail Address

Director, Division of Medical Services

Title

12/15/2023

Date

TOC required**145.000 Electronic Visit Verification (EVV) for In-Home Personal Care, Attendant Care, Respite-Services, and Home Health Services****145.100 Legal Basis and Scope of EVV Requirement****1-1-24**

In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) is implementing an electronic visit verification (EVV) system for in-home personal care services (PCS), attendant care, respite services, and home health services paid by Medicaid.

An EVV system is a telephone, computer, or other technology-based system under which visits conducted as part of personal care services or home health care services are electronically verified with respect to:

- A. The type of service(s) performed;
- B. The individual receiving the service(s);
- C. The date of the service(s);
- D. The location of service delivery;
- E. The individual providing the service(s); and
- F. The time the service(s) begins and ends.

The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid PCS, attendant care, respite care, and home health care provided during an in-home visit under the Medicaid State Plan, the Provider-Led Arkansas Shared Savings Entity (PASSE), the ARChoices Medicaid §1915(c) Home and Community-Based Services Waiver, or under any self-direction plan.

PCS, attendant care, respite services, and home health services provided to more than one (1) person throughout a shift in 24-hour residential settings are not subject to the EVV requirement because they do not involve an “in-home” visit. This includes without limitation: PCS, attendant care, respite services, and home health services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

PCS, attendant care, respite services, and home health services provided to a student in a public school are not subject to the EVV requirement because they do not involve an “in-home” visit.

Additional information regarding EVV is available from the DHS EVV Vendor. [View or print the DHS EVV Vendor contact information.](#)

145.200 EVV Participation Requirements**1-1-24**

To submit a claim for any service that is subject to the EVV requirement or pay based upon a self-directed plan of care subject to the EVV requirement, a provider must:

- A. Submit and maintain on file with both DHS Provider Enrollment and the DHS EVV Vendor a contact e-mail address for the provider. The e-mail address must be an address that is active and is controlled and regularly checked by the provider. The e-mail address must be

a business address that is unique to the provider and must not be an employee's personal e-mail address or other shared address. The e-mail address submitted by a provider to DHS Provider Enrollment will be the e-mail address used by the DHS EVV Vendor to create the provider's account to access the EVV system;

- B. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every caregiver employed or contracted by the provider to furnish care for which Medicaid PCS, attendant care, or respite care claims may be submitted;
- C. Submit, with every claim for a service subject to the EVV requirement, the PIN for the caregiver providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID number;
- D. Use an EVV system that documents and verifies every in-home visit resulting in a claim for reimbursement. A provider must use the EVV system furnished by the DHS EVV Vendor or they must use a third-party EVV system that has been certified by the DHS EVV Vendor;
- E. Require caregivers, that are employed or contracted by the provider, to use EVV for all in-home Medicaid-paid PCS, attendant care, respite care, and home health care and to train the caregivers on the use of the provider's chosen EVV system;
- F. If the provider uses the DHS EVV system, register the provider's caregivers with the EVV system. By registering a caregiver with the DHS EVV system, the provider is attesting that all applicable requirements, including without limitation training requirements, have been satisfied for that caregiver (A caregiver who is excluded or debarred from participation in Medicaid under any state or federal law is not eligible to register with the DHS EVV system);
- G. Create and maintain documentation to justify any manual modifications, adjustments, or exceptions made by the provider in the EVV system after a caregiver has entered or failed to enter any required information;
- H. Comply with EVV requirements established by the Centers for Medicare & Medicaid Services (CMS);
- I. Comply with applicable federal and state laws regarding confidentiality of information about beneficiaries receiving services; and
- J. Ensure that DHS may review documentation generated by an EVV system or obtain a copy of that documentation at no charge.

145.300 EVV Claims Requirements

1-1-24

EVV is required for the following procedure codes and modifiers when the Place of Service is coded as the beneficiary's home (POS code 12):

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) Beneficiary Under 21
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older
S5125	U2	Agency Attendant Care Traditional
S5150		Respite Care – In-Home
T1021	TD	Home Health RN Visit, per visit
T1021	TE	Home Health LPN Visit, per visit

Procedure Code	Modifier	Service Description
T1021		Home Health Aide Visit
S9131	UB	Home Health Physical Therapy by a Qualified Physical Therapy Assistant
S9131		Home Health Physical Therapy by a Qualified Licensed Physical Therapist

A claim for any of these procedure codes and modifiers may be rejected or denied, or subject to recoupment, if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

- A. The data submitted in the claim;
- B. The data recorded by EVV for the claimed service;
- C. The data in the approved prior authorization or plan of care applicable to the claimed service; or
- D. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

A claim for any of these procedure codes and modifiers is subject to the EVV requirement regardless of how the claim is submitted, including third-party EVV vendors, through a PASSE claims system, or through a self-direction plan.

For PCS, attendant care, respite and Home Health services delivered in a beneficiary's home, it is a fraudulent billing practice to list any Place of Service (POS) code other than POS code 12, unless the Provider Manual or other Rule explicitly permits the use of a different POS code.

- A. The EVV Requirement also applies to any equivalent services provided to a beneficiary through the Independent Choices program, or any other self-direction program made available under the state plan or ARChoices. Such equivalent services may be rejected or denied if delivery of the service was not verified by EVV or if there is any inconsistency among or between:
 - 1. The data submitted in the claim;
 - 2. The data recorded by EVV for the claimed service;
 - 3. The data in the approved prior authorization or the plan of care that is applicable to the claimed service; or
 - 4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

TOC required

261.100 Electronic Visit Verification (EVV)

1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding attendant care and respite care services.

TOC required

241.100 Electronic Visit Verification (EVV)

1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding home health services.

TOC required

261.100 Electronic Visit Verification (EVV)

1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding personal care services.

RULES SUBMITTED FOR REPEAL

Rule #1:

DDS Policy 1027 – Incident Reporting Procedural Guidelines-

Rule #2:

DDS Policy 1035 – Agency Definition of Disability/Eligibility for Services.

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL~~

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

~~Procedural Guidelines for DHS Policy 3002-I, Incident Reporting.~~

- ~~1. The employee(s) or volunteer(s) first having knowledge of a reportable incident shall immediately report to the on-site administrator (specific chain of reporting will be according to procedures developed at the program site).~~
- ~~2. The employee(s) or volunteer(s) utilizing Attachment #1 will immediately document the incident details and provide the form to the on-site administrator.~~
- ~~3. Within one (1) hour of determination of an applicable incident, the on-site administrator will make verbal/fax notification to the following individuals:~~

~~A. DDS Director/Designee
682-8665~~

~~NOTIFY IN ALL INCIDENTS~~

~~B. DHS Advocate: Marsha Smith
682-8650~~

~~NOTIFY IN ALL INCIDENTS~~

~~C. DDS Licensure
682-8697~~

~~NOTIFY IN ALL INCIDENTS IN COMMUNITY PROGRAMS~~

REPEAL-EO 23-02

~~Replacement Notation: This procedural guideline replaces DDS Commissioner's Policy #1027 effective December 14, 1981 and January 8, 1987.~~

~~Effective Date: December 1, 1993~~

~~Sheet 1 of 4~~

~~References: DHS Policy 3002-I plus attachments.~~

~~Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council: November 4, 1993.~~

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES~~
~~DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES~~
~~DDS DIRECTOR'S OFFICE POLICY MANUAL~~

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

- ~~4. Additional notifications will be made to the following individuals/offices when specific incident(s) occur:~~

REPEAL-EO 23-02

~~X-Notification~~

~~Effective Date: December 1, 1993~~

~~Sheet 2 of 4~~

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL~~

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

~~Attachment 2 shall be utilized for documenting notification and made a part of incident/investigative files.~~

- ~~5. The on-site administrator will initiate and ensure prompt investigation, when required and unless otherwise directed by outside agencies (i.e., Law Enforcement, Coroner, State Medical Examiner, Prosecuting Attorney). Internal investigation will be conducted according to DDS Procedural Guidelines for Investigation if the incident is at a state operated institution/program.~~
- ~~6. The on-site administrator will be the primary point of contact with external sources unless otherwise determined.~~
- ~~7. The on-site administrator will submit a written report (summary to date or final report) of the incident/investigation within three (3) days of the initial reporting to all those initially notified, and any external authority so requesting.~~
- ~~8. The on-site administrator will submit a final report/investigative file of any reported incident, within time frames established by applicable Policy, depending on the specific incident. All final reports will be forwarded to the appropriate Supervisor. The DDS Director shall provide report copies to all those initially notified, External Authorities and/or others as necessary/requested.~~
- ~~9. The on-site administrator is responsible for the development of on-site procedures, in the absence of Departmental/Divisional Policy/Procedure, specific to the following items which comply with DHS Policy #3002-I and DDS Procedural Guidelines #1027 as well as those incidents not covered by #3002-I and #1027.~~
 - ~~A. Unusual Client Deaths and/or Serious Injuries~~
 - ~~B. Absence (Run-away) and Search Procedures~~
 - ~~C. Criminal Activity~~
 - ~~D. Maltreatment - Prevention, Reporting and Investigating~~
 - ~~E. Natural Disasters (Emergency Preparedness)~~
 - ~~F. Serious Accidents~~
 - ~~G. Disruption of Service~~

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES~~
~~DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES~~
~~DDS DIRECTOR'S OFFICE POLICY MANUAL~~

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

~~10. On-site procedures shall include but not necessarily be limited to the following:~~

- ~~A. Reporting/Notification requirements~~
- ~~B. Staff/Volunteer Responsibilities~~
- ~~C. Documentation~~
- ~~D. Training Requirements for Staff~~
- ~~E. Specific tasks/assignments (who does what, when) of staff~~
- ~~F. Applicability to DHS Policy #3002-I~~

REPEAL-EO 23-02

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and LOCAL DIVISION OF CHILDREN AND FAMILY SERVICES:	+	X	+	X	+	X	+	X
INDIVIDUAL OVER 18 (ADULT PROTECTIVE SERVICES)	+		+		+		+	
1-800-482-8049 or 682-2441	+	X	+	X	+	X	+	X
OFFICE OF LONG TERM CARE	+	X	+	X	+	X	+	X
682-8487	+		+		+		+	
OFFICE OF EMERGENCY SERVICES	+		+		+		+	
Office:	+		+		+		+	X
Home:	+		+		+		+	
ARKANSAS DEPARTMENT OF HEALTH	+		+		+		+	X
661-2316	+		+		+		+	
DIRECTOR, COTTAGE LIFE/TEAM LEADER	+	X	+	X	+	X	+	X
NURSING SERVICES ADMIN.	+	X	+	X	+	X	+	X
SOCIAL SERVICE	+	X	+	X	+	X	+	X
DIRECTOR, HAB & TRAINING	+	X	+	X	+	X	+	X
PHYSICIAN	+	X	+	X	+	X	+	X
PARENT/GUARDIAN (NEXT OF KIN)	+	X	+	X	+	X	+	X
OTHER:	+		+		+		+	

X = Notification

TIME NOTIFIED		COMMENTS AND NOTES
REPEAL-EO 23-02		

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL~~

Policy Type	Subject of Policy	Policy No.
Administrative	Agency Definition of Disability/Eligibility for Services	1035

- ~~1. Purpose. This policy has been prepared to set minimum parameters for determining eligibility to receive services from Developmental Disabilities Services (DDS).~~
- ~~2. Scope. All individuals and their families applying for services offered by DDS.~~
- ~~3. Definitions. For purposes of this policy, Primary Disability/Condition, Primary Diagnosis, and Other Disabilities are defined as follows:~~

- ~~A. Primary Disability - That condition which renders the most serious impairment and/or condition which has the greatest impact on an individual's ability to function, as outlined in Arkansas Statute Ann. 20-48-101.~~
- ~~B. Primary Diagnosis - A medical designation, determined by a physician, usually denoting etiology of disabling condition.~~
- ~~C. Other Disabilities - Any condition(s) which accompanies the primary disability, and further hinders the development of an individual.~~

- ~~4. Eligibility Criteria.~~

- ~~A. Diagnosis of developmental disability under definition cited in Arkansas Code Ann. § 20-48-101.~~

- ~~1) Is attributable to intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy or autism spectrum disorder.~~

- ~~a. Intellectual Disability - As established by scores of intelligence which fall two or more standard deviations below the mean of a standardized test of intelligence administered by a legally qualified professional; Infants/Preschool, 0-5 years - developmental scales, administered by qualified personnel authorized in the manual accompanying the instrument used, which indicate impairment of general functioning similar to that of developmentally disabled persons;~~
- ~~b. Cerebral Palsy - As established by the results of a medical examination provided by a licensed physician;~~
- ~~c. Spina bifida - As established by the results of a medical examination provided by a licensed physician.~~
- ~~d. Down syndrome - As established by the diagnosis of a licensed physician.~~

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES
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- ~~e. Epilepsy - As established by the results of a neurological and/or licensed physician;~~
- ~~f. Autism Spectrum Disorder - As established by the results of a team evaluation including at least a licensed physician and a licensed psychologist and a licensed Speech Pathologist;~~

~~NOTE: Each of these four conditions is sufficient for determination of eligibility independent of each other. This means that a person who is intellectually disabled does not have to have a diagnosis of autism spectrum disorder, epilepsy, spina bifida, down syndrome, or cerebral palsy. Conversely, a person who has autism spectrum disorder, cerebral palsy, epilepsy, spina bifida, or Down syndrome does not have to have an intellectual disability to receive services.~~

- ~~2) Is attributable to any other condition of a person found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with intellectual disability or requires treatment and services similar to those required for such persons. This determination must be based on the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.~~

REPEAL-EO 23-02

- ~~a) In the case of individuals being evaluated for service, eligibility determination shall be based upon establishment of intelligence scores which fall two or more standard deviations below the mean of a standardized test of intelligence OR, is attributable to any other condition found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability, or requires treatment and services similar to those required for such persons.~~
- ~~b) Persons age 5 and over will be eligible for services if their I.Q. scores fall two or more standard deviations below the mean of a standardized test.~~
- ~~c) For persons ages 3 to 5, eligibility is based on an assessment that reflects functioning on a level two or more standard deviations from the mean in two or more areas as determined by a standardized test.~~

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~~d.) For infants and toddlers 0-36 months, eligibility for DDS Services will be indicated by a 25% delay in two or more areas based on an assessment instrument which yields scores in months. The areas to be assessed include: cognition; communication; social/emotion; motor; and adaptive.~~

- ~~3) Is attributable to dyslexia resulting from intellectual disability, cerebral palsy, epilepsy spina bifida, Down syndrome or autism spectrum disorder as established by the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.~~

~~NOTE: In the case of individuals being evaluated for service, eligibility shall be based upon their condition closely related to an intellectual disability by virtue of their adaptive behavior functioning.~~

- ~~B. The disability must originate prior to the date the person attains the age of twenty-two (22).~~

~~NOTE: When age becomes a factor in eligibility determination under the Arkansas Law, such a case will be evaluated on its own merit as to whether the condition resulting from the disability was present before age twenty-two (22). In such cases, the determining authority will be the Assistant Director of Client Services and/or the Director for Developmental Disabilities Services.~~

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- ~~C. The disability has continued or can be expected to continue indefinitely.~~
- ~~D. The disability constitutes a substantial handicap to the person's ability to function without appropriate support services including, but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment.~~
- ~~5. Services. Given the availability of funds and subject to budget restrictions, DDS will provide services to eligible persons.~~
- ~~6. Appeal. Should the individual and parent/guardian disagree with the decision made, they retain the right of appeal following DDS Policy #1076.~~

~~Replacement Notation: This policy replaces DDS Commissioner's Office Policy 1035, Eligibility for Services, effective June 29, 1981; May 10, 1982; and October 7, 1983 and DDS Deputy Director's Policy #1035, January 8, 1988, December 1, 1993.~~

REPEAL-EO 23-02

~~Effective Date:~~

~~Sheet 1 of 4~~

~~References: Arkansas Code Ann. 20-48-101, DDS Policy #1075, and DDS Policy #1020~~

~~Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council: January 16, 2018~~

~~ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL~~

Policy Type	Subject of Policy	Policy No.
Administrative	Agency Definition of Disability/Eligibility for Services	1035

~~ATTACHMENT 1~~

~~DDS Administrative Policy No. 1035 – Agency Definition of Disability
Eligibility for Services~~

- ~~1. Referral is to include a memorandum by DDS Counselor with reason(s) for referral, why DDS eligibility is not clear, what are the reasons for dispute, and the referring person's own recommendation.~~
- ~~2. Adaptive Behavior Scale (within the last year).~~
- ~~3. Current Medical status (within the last year).~~
- ~~4. Psychological evaluation (within the last year) if eligibility request is based on psychological reasons.~~
- ~~5. Results of special evaluations relevant to eligibility determination.~~
- ~~6. Documentation by Service Coordinator or client observation within the last three (3) months.~~
- ~~7. Social History completed within the last 90 days by DDS Counselor.~~
- ~~8. The most recent Individual Education Plan if person is school age.~~
- ~~9. For individuals who are not school age, program plan of current or past services providers, if any.~~

REPEAL-EO 23-02