



Arkansas Department of Health and Human Services



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TO: Arkansas Medicaid Alternatives for Adults with Physical Disabilities
Waiver Providers

DATE: June 1, 2006

SUBJECT: Provider Manual Update Transmittal #32

REMOVE

Section	Date
201.100	10-13-03
212.000	10-13-03
212.300-212.400	10-13-03
213.200	6-1-04
215.000	10-13-03
220.000	6-1-04
232.000	10-13-03
240.000	6-1-04
241.000	6-1-04
242.000	6-1-04
242.100	6-1-04
242.200	10-13-03
242.300	6-1-04
None	
242.310	10-13-03
242.400-243.100	6-1-04
243.200-243.400	6-1-04

INSERT

Section	Date
201.100	6-1-06
212.000	6-1-06
212.300-212.400	6-1-06
213.200	6-1-06
215.000	6-1-06
220.000	6-1-06
232.000	6-1-06
240.000	6-1-06
241.000	6-1-06
None	
241.100	6-1-06
241.200	6-1-06
242.000	6-1-06
242.100	6-1-06
242.110	6-1-06
242.200-242.300	6-1-06
None	

Explanation of Updates

The agency name has changed from Arkansas Department of Human Services to Arkansas Department of Health and Human Services. Therefore, references to the "Department of Human Services" have been changed to the "Department of Health and Human Services", and references to "DHS" changed to "DHHS" throughout the policy. Additionally, all references to "recipients" throughout the policy have been changed to "beneficiaries."

Section 220.000 has been revised to remove the requirement for prior authorization as the prior authorization requirement was never implemented. Prior authorization is not required in the Alternatives for Adults with Physical Disabilities Waiver category.

Sections 240.000 – 243.400, Billing Procedures, have been reorganized and renumbered to 240.000 - 242.210 for clarity. Sections 243.200 – 243.400 have been deleted.

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Paper versions of this update transmittal have updated pages attached to file 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 need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices 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.

Roy Jeffus, Director

SECTION II - ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES WAIVER

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

6-1-06

Providers of Alternatives for Adults with Physical Disabilities Waiver services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet all Arkansas Medicaid participation requirements outlined in Section 201.000.

A routine services provider may be enrolled in the program as a provider of routine Alternatives services to eligible Arkansas Medicaid beneficiaries. Reimbursement may be available for all attendant care and environmental accessibility adaptation/adaptive equipment services covered in the Arkansas Medicaid Program. Claims must be filed according to Section 240.000 of this manual.

212.000 Eligibility Assessment

6-1-06

The client intake and assessment process includes application for waiver services at the Department of Health and Human Services (DHHS) county office in the client's resident county, a determination of categorical eligibility, a nursing facility level of care determination, the development of a plan of care, a cost comparison to determine the cost-effectiveness of the plan of care and notification of a choice between home and community-based services and institutional services.

212.300 Temporary Absences From the Home

6-1-06

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

A. Absence from the Home – Institutionalization

An individual cannot receive waiver services while in an institution. The following policy applies to active waiver cases when the individual is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver beneficiary is admitted to a hospital, the DHHS county office will not take action to close the waiver case, unless the beneficiary does not return home within 20 days from the date of admission. If, after 20 days, the beneficiary has not returned home, the waiver counselor will notify the DHHS county office via form DHHS-3330 and action will be initiated by the DHHS county office to close the waiver case.
2. If the DHHS county office becomes aware that a client has been admitted to a nursing facility and it is anticipated that the stay will be short (20 days or less), the waiver case will be closed effective the date of admission, but the Medicaid case will be left open. When the individual returns home, the waiver case may be reopened effective the date the client returns home.

B. Absence from the Home - Non-Institutionalization

When a waiver client is absent from the home for reasons other than institutionalization, the DHHS county office will not be notified unless the client does not return home within 20 days. If, after 20 days, the client has not returned home and the providers can no longer deliver services as prescribed by the plan of care (e.g., the client has left the state and the return date is unknown), the waiver counselor will notify the DHHS county office. Action will be taken by the DHHS county office to close the waiver case. No alternatives services are covered during a client's absence.

212.400 Reporting Changes in Client's Status

6-1-06

Because the provider has more frequent contact with the client, the provider may become aware of changes in the client's status sooner than the Waiver Counselor or DHHS County Office. It is the provider's responsibility to report these changes immediately so proper action can be taken. Providers must complete the Provider Communication Form (AAS-9502) and send it to the waiver counselor. A copy must be retained in the provider's client case record. Whether the change may or may not result in action by the DHHS county office, providers must report all changes in the client's status to the waiver counselor.

213.200 Attendant Care Service

6-1-06

Attendant care service is assistance to a medically stable, physically disabled individual in accomplishing tasks of daily living that the individual is unable to complete independently. Assistance may vary from actually doing a task for the individual, to assisting the individual to perform the task or to providing safety support while the individual performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished.

- A. If consumer-directed care is selected then a consumer-directed approach will be used in the provision of attendant care services. Each individual who elects to receive attendant care services must agree to and be capable of recruiting, hiring, training, managing and terminating attendants. The client must also monitor attendant service timesheets and approve payment to the attendant for services provided by signing the timesheets.

Clients who can comprehend the rights and accept the responsibilities of consumer-directed care may wish to have alternatives attendant care services included on their plan of care. The client's plan of care will be submitted to the client's attending physician for his or her review and approval.

- B. The Evaluation of Need for Nursing Home Care Form (DHHS-703) completed by the waiver counselor for each Alternatives Waiver applicant will contain information relative to the client's functional, social and environmental situation.
- C. Clients receiving attendant care will not be able to access personal care that is a duplication of APD services. However, receiving attendant care services does not automatically preclude the client from receiving personal care services. Medically necessary personal care may be provided, but only if it is included in the evaluation and plan of care and is not a duplication of services. The personal care service plan must be attached to the APD plan of care.
- D. To aid in the attendant care recruitment process, clients will be apprised of the minimum qualifications set forth for provider certification (See section 213.220) and the Medicaid enrollment and reimbursement process. The client will be instructed to notify the waiver counselor when an attendant has been recruited. The waiver counselor will facilitate the development of a formal service agreement between the client and the attendant, using the form AAS-9512, Attendant Care Service Agreement.
- E. When the AAS-9512, Attendant Care Service Agreement, is finalized, the attendant will apply for DAAS certification and Medicaid provider enrollment. The waiver counselor will assist as needed to expedite this process. As an enrolled Medicaid provider, the attendant will be responsible for all applicable Medicaid participation requirements, including claims submission.
- F. Refer to section 243.100 of this manual for the procedure code to be used with filing claims for this service.

215.000 Client Appeal Process

6-1-06

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

Appeal requests must be submitted to the Department of Health and Human Services Appeals and Hearings Section. [View or print DHHS Appeals and Hearings Section contact information.](#)

220.000 PRIOR AUTHORIZATION

6-1-06

Prior authorization is not required in this program.

232.000 Rate Appeal Process 6-1-06

A provider may request reconsideration of a Medicaid Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification to the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and, if necessary, will contact the provider to arrange a conference. Regardless of the Program decision, the provider will be afforded the opportunity for a full explanation of the factors involved and the Program decision. Within 20 calendar days of receipt of the request for review, the Assistant Director will notify the provider of the action to be taken by the Division or the date for the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES 6-1-06

241.000 Introduction to Billing 6-1-06

Alternatives for Adults with Physical Disabilities Waiver providers use the CMS-1500 form and the Alternatives Attendant Care Provider Claim Form (AAS-9559) to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

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

241.100 Alternatives Waiver Procedure Codes 6-1-06

The following procedure codes must be billed with a type of service “9”:

Procedure Code	Description
S5165	Environmental Accessibility Adaptations/Adaptive Equipment
S5125	Attendant Care

241.200 Place of Service and Type of Service Codes 6-1-06

Place of Service	Paper Claims	Electronic Claims	Type of Service (paper only)
Patient’s Home	4	12	9 - Alternatives Waiver

242.000 Billing Instructions - Paper Only

6-1-06

Claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

242.100 CMS Billing Procedures

6-1-06

To bill for environmental accessibility adaptations/adaptive equipment services, use the CMS-1500. The numbered items correspond to numbered fields on the claim form. [View a sample CMS-1500 form.](#) The following instructions must be read and carefully followed so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the EDS Claims Department. [View or print EDS Claims Department contact information.](#)

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

242.110 Completion of CMS-1500 Claim Form

6-1-06

Field Name and Number	Instructions for Completion
1. Type of Coverage	This field is not required for Medicaid.
a. Insured’s I.D. Number	Enter the patient’s 10-digit Medicaid identification number.
2. Patient’s Name	Enter the patient’s <u>last</u> name and <u>first</u> name.
3. Patient’s Birth Date	Enter the patient’s date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
Sex	Check “M” for male or “F” for female.
4. Insured’s Name	Required if there is insurance affecting this claim. Enter the insured’s <u>last</u> name, <u>first</u> name and <u>middle</u> initial.
5. Patient’s Address	Optional entry. Enter the patient’s full mailing address, including street number and name (post office box or RFD), city name, state name and zip code.
6. Patient Relationship to Insured	Check the appropriate box indicating the patient’s relationship to the insured if there is insurance affecting this claim.
7. Insured’s Address	Required if insured’s address is different from the patient’s address.
8. Patient Status	This field is not required for Medicaid.
9. Other Insured’s Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured’s <u>last</u> name, <u>first</u> name and <u>middle</u> initial.
a. Other Insured’s Policy or Group Number	Enter the policy or group number of the other insured.

Field Name and Number	Instructions for Completion
b. Other Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
c. Employer's Name or School Name	Enter the employer's name or school name.
d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10. Is Patient's Condition Related to:	
a. Employment	Check "YES" if the patient's condition was related to employment (current or previous). If the condition was not employment related, check "NO."
b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two-letter state postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
d. Reserved for Local Use	This field is not required for Medicaid.
11. Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
a. Insured's Date of Birth	This field is not required for Medicaid.
Sex	This field is not required for Medicaid.
b. Employer's Name or School Name	Enter the insured's employer's name or school name.
c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12. Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13. Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14. Date of Current: Illness Injury Pregnancy	Not required.
15. If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16. Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.

Field Name and Number	Instructions for Completion
17. Name of Referring Physician or Other Source a. I.D. Number of Referring Physician	Primary Care Physician (PCP) referral is not required for Alternatives for Adults with Physical Disabilities waiver services. Enter the 9-digit Medicaid provider number of the referring physician.
18. Hospitalization Dates Related to Current Services	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
19. Reserved for Local Use	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
20. Outside Lab?	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim receipt dates.
22. Medicaid Resubmission Code Original Ref No.	Reserved for future use. Reserved for future use.
23. Prior Authorization Number	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
24. A. Dates of Service B. Place of Service C. Type of Service D. Procedures, Services or Supplies CPT/HCPCS Modifier	Enter the “from” and “to” dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two or more <i>sequential</i> dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span. Enter the appropriate place of service code. See Section 242.200 for codes. Enter the appropriate type of service code. See Section 242.200 for codes. Enter the correct CPT or HCPCS procedure code from Section 242.100. Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.

Field Name and Number	Instructions for Completion
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number (“1,” “2,” “3,” “4”) from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. \$ Charges	Enter the charge for the service. This charge should be the provider’s usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Not applicable to Alternatives for Adults with Physical Disabilities Waiver claims.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.
K. Reserved for Local Use	Not required.
25. Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.
26. Patient’s Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient’s account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27. Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28. Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29. Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the beneficiary .
30. Balance Due	<p>Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge.</p> <p>NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.</p>

Field Name and Number	Instructions for Completion
31. Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and zip code of the facility where services were performed.
33. Physician's/Supplier's Billing Name, Address, ZIP Code & Phone # PIN # GRP #	Enter the billing provider's name and complete address. Telephone number is requested but not required. This field is not required for Medicaid. Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

242.200 Alternatives Attendant Care Provider Claim Form (AAS-9559) Billing Instructions

6-1-06

EDS offers providers several options for electronic billing. Claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for attendant care services, use the Alternatives Attendant Care Provider Claim Form (AAS-9559). [View a sample Alternatives Attendant Care Provider Claim Form \(Form AAS-9559.\)](#) The following instructions must be read and carefully followed so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

242.210 Completion of Alternatives Attendant Care Provider Claim Form

6-1-06

Form AAS-9559 is obtained from the client's employer after the top portion of the form is completed by the Division of Aging and Adult Services (DAAS) Waiver Counselor. The form must be signed by the client or an authorized person.

The middle portion of the form is used by the provider to record the amount of time worked by entering the information requested on the form.

The bottom section of the form is for provider identification information. The prior authorization number for authorized services must be entered on the line where indicated. The provider must

sign the form. Refer to the DAAS Attendant Care Provider Manual for complete billing information.

242.300 Special Billing Procedures

6-1-06

Claims for attendant care services must be filed in 15 minute units with a daily maximum of 32 units.

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

When filing paper claims for attendant care, Form AAS-9559 must be used.