



Arkansas Department of Health and Human Services



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

DATE: July 1, 2007

SUBJECT: Provider Manual Update Transmittal #55

REMOVE

Section	Date
201.000	12-26-05
201.100	6-1-06
211.000	10-13-03
212.100	10-13-03
212.200	10-13-03
212.300	6-1-06
212.400	6-1-06
213.100	10-13-03
213.110	10-13-03
213.200	6-1-06
213.210	10-13-03
213.220	10-13-03
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214.000	10-13-03
215.000	10-13-03
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INSERT

Section	Date
201.000	7-1-07
201.100	7-1-07
211.000	7-1-07
212.100	7-1-07
212.200	7-1-07
212.300	7-1-07
212.400	7-1-07
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—	—	216.510	7-1-07
—	—	219.000	7-1-07
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242.110	6-1-06	242.110	7-1-07
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242.210	6-1-06	242.210	7-1-07
—	—	242.310	7-1-07
—	—	242.320	7-1-07

Explanation of Updates

This update provides new information concerning the APD waiver program and Attendant Care services. Consumer-directed Attendant Care has been added as a new APD service. The maximum number of days an individual can be institutionalized or otherwise absent from home before the county office is notified to begin case closure proceedings has been changed from 20 to 30 days. Additionally, “alternatives counselor” has been changed to “DAAS Rehab Counselor or RN” throughout the policy.

Section 201.000 is included to provide information regarding certification of Consumer-Directed Attendant Care, Consumer-Directed Agency Attendant Care, Traditional Agency Attendant Care, Environmental Accessibility/Adaptations/Adaptive Equipment and Case Management/Counseling Support.

Section 201.100 is included to add information that case management services are covered by Medicaid.

Section 211.000 is included to add information that disability for individuals age 21 through 64 must be determined by SSI/SSA or the DHHS Medical Review Team and that Alternatives individuals turning 65 will be allowed to remain on the Alternatives waiver. Agency Attendant Care – Consumer Directed, Agency Attendant Care – Traditional or Consumer-Directed, and Case Management/Counseling Support have been added as community-based services for APD beneficiaries.

Section 212.100 includes information regarding level of care determination.

Section 212.200 changes the Alternatives Plan of Care form to AAS-9503 and changes the word “Counselor” to “Rehab Counselor or RN”. A statement has also been added that the service provider and the Alternatives client must review and follow the signed authorized plan of care.

Section 212.300 changes the number of day’s absence due to institutionalization or other absence from the home from 20 to 30 days before the absence is reported to the county office.

Section 212.400 is included to change “counselor” to “DAAS Rehab Counselor or RN”.

Section 213.100 is included to change “counselor” to DAAS Rehab Counselor or RN”.

Section 213.110 is included to add additional information regarding the cap for environmental accessibility adaptations/adaptive equipment.

Section 213.200 is included to add additional information regarding Attendant Care services.

Section 213.210 is included to provide additional information regarding tasks related to Attendant Care services.

Section 213.220 has been added to provide information regarding benefit limits for Attendant Care services.

Section 213.230 has been renumbered from 213.220. This section contains wording changes.

Section 213.300 is a new section regarding Agency Attendant Care.

Section 213.310 is a new section regarding tasks related to Agency Attendant Care.

Section 213.320 is a new section regarding benefit limits for Agency Attendant Care.

Section 213.330 is a new section regarding provider qualifications for Agency Attendant Care.

Section 213.400 is a new section regarding covered Case Management/Counseling Support Services.

Section 214.000 is a revision of the documentation section.

Section 215.000 is a revision of the records retention section.

Section 215.100 is a new section regarding time records.

Section 216.100 is a new section regarding assessments and service plan development.

Section 216.200 is a new section regarding service management.

Section 216.300 is a new section regarding service monitoring and service plan updating.

Section 216.400 is a new section regarding support of financial management services.

Section 216.500 is a new section regarding counseling support.

Section 216.510 is a new section regarding benefit limits.

Section 219.000 is a renumbering of the previous section 215.000.

Section 241.00 revises the Introduction to Billing section.

Section 241.100 adds new codes for Attendant Care, Counseling and Case Management.

Section 242.000 is a new section of billing instructions.

Section 242.100 was previously section 242.000.

Section 242.110 was previously section 242.100. The first sentence of this section has been deleted.

Section 242.200 has been revised with new information added regarding billing of Consumer-Directed Attendant Care.

Section 242.201 has been revised with new information added regarding completion of the AAS-9559.

Section 242.210 has been revised to add billing instructions for Agency and Consumer-Directed Attendant Care.

Section 242.310 has been revised to add information about filing claims for Consumer-Directed Attendant Care.

Section 242.311 has been added to provide information regarding billing of Agency Attendant Care services.

Section 242.320 has been added to provide information regarding Environmental Modifications/Adaptive Equipment.

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 (TDD only).

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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200.000 ALTERNATIVES FOR ADULTS WITH PHYSICAL DISABILITIES WAIVER GENERAL INFORMATION

201.000 Arkansas Medicaid Enrollment Requirements for Alternatives for Adults with Physical Disabilities (Alternatives Waiver) 7-1-07

Provider participation in the Arkansas Medicaid Alternatives for Adults with Physical Disabilities Waiver Program (Alternatives Waiver) requires the following:

A. Consumer-Directed Attendant Care

Consumer-Directed Attendant Care must be certified by the Division of Aging and Adult Services (DAAS) as having met all Centers for Medicare and Medicaid Services (CMS)-approved provider criteria for the services to be provided. Providers of Alternatives Waiver Attendant Care and Environmental Accessibility/Adaptation Services must be certified by the Division of Aging & Adult Services (DAAS) as having met all CMS approved provider criteria for the service(s) to be provided.

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

B. Consumer-Directed Agency Attendant Care

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

C. Traditional Agency Attendant Care

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

D. Environmental Accessibility/Adaptations/Adaptive Equipment

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

E. Case Management/Counseling Support

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

It is the responsibility of all providers of Alternatives Waiver services to maintain current Division of Aging and Adult Services (DAAS) certification to avoid loss of provider eligibility. Required materials must be submitted to the Division of Aging and Adult Services. [View or print the Division of Aging and Adult Services contact information.](#) Certifications are renewed annually. If required recertification documents are not received by the Division of Aging and Adult Services prior to expiration of the current certificate, action will be taken to close the provider's identification number and Medicaid provider number.

Providers must complete a provider application (form DMS-652) a Medicaid contract, (form DMS-653) and a Request for Taxpayer Identification Number and Certification (W-9) for submission to the Arkansas Medicaid Program. [View or print a provider application \(Form DMS-652\), Medicaid contract \(Form DMS-653\) and Request for Taxpayer Identification Number and Certification \(Form W-9\).](#)

A copy of the current DAAS certification, licensure, etc., must accompany the provider application and Medicaid contract. Subsequent renewals of certification must be forwarded to EDS Provider Enrollment within 30 days of issuance. [View or print DMS Provider Enrollment Unit contact information.](#) If the renewal document(s) have not been received within thirty (30) days, the provider will have an additional, and final, thirty (30) days to comply. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule, are not eligible to enroll, or to remain enrolled, as Medicaid providers.

201.100 Providers of Alternatives for Adults with Physical Disabilities Waiver Services in Arkansas and Bordering States 7-1-07

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 Services, Environmental Accessibility Adaptation/Adaptive Equipment Services, and Case Management Services covered in the Arkansas Medicaid Program. Claims must be filed according to Section 240.000 of this manual.

210.000 PROGRAM COVERAGE

211.000 Scope 7-1-07

The Arkansas Medicaid Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to disabled individuals age 21 through 64 who have received a determination of physical disability by SSI/SSA or DHHS Medical Review Team (MRT) and who, without the provision of home and community-based services, would require a nursing facility (NF) level of care. The participant's income must be equal to or less than 300% of the SSI eligibility limit.

NOTE: Alternatives Participants Turning Age 65.

Individuals who are active participants in the Alternatives Waiver at the time they turn age 65 will be allowed to remain on the Alternatives Waiver, if they so choose. Individuals aged 65 and over will not be allowed to apply for the Alternatives Waiver. Regardless of previous participation, once an Alternatives Waiver case is closed, unless in error by the Department of Health and Human Services, the applicant may not reapply for the APD program if aged 65 or older.

The community-based services offered through the Alternatives for Adults with Physical Disabilities Home and Community-Based Waiver, described herein as Alternatives, are as follows:

1. Environmental Accessibility Adaptations/Adaptive Equipment
2. Agency Attendant Care – Consumer-Directed
3. Agency Attendant Care – Traditional and Consumer-Directed

4. Case Management/Counseling Support

These services are designed to maintain Medicaid eligible beneficiaries at home in order to preclude or postpone institutionalization of the individual.

Please note that in accordance with 42 CFR 441.301 (b)(1)(ii), alternatives services are not covered for inpatients of nursing facilities, hospitals or other inpatient institutions.

212.100 Level of Care Determination

7-1-07

A prospective Alternatives participant must require a nursing facility level of care. The level of care determination is made by the Office of Long Term Care based on an assessment process performed by a DAAS Rehabilitation Counselor (Rehab Counselor) or DAAS registered nurse (RN), using standard criteria for evaluating an individual's need for nursing home placement in the absence of community alternatives.

Medical or long-term care level of care reevaluations will occur annually. The results of the level of care determination and the reevaluation are documented respectively on the DCO-704-Decision for Nursing Home Placement Form.

NOTE: While federal guidelines require level of care reassessment at least annually, the Division of Aging and Adult Services may reassess a participant's level of care and/or need any time it is deemed appropriate by the DAAS Rehab Counselor or RN.

212.200 Plan of Care

7-1-07

- A. Each client eligible for services must have an individualized Alternatives Plan of Care (AAS-9503). The authority to develop an Alternatives plan of care is given to the Medicaid state agency's designee, the Division of Aging and Adult Services Rehab Counselor or RN. The alternatives plan of care is developed in negotiation with the Alternatives participant or legal representative or both and, at the discretion of the participant, or the participant's family.
- B. The Alternatives plan of care supersedes all other plans of care developed for a participant. The information in the plan of care will include, but is not limited to, the following:
 - 1. Participant identification information to include full name and address, Medicaid number and the participant's waiver eligibility effective date and expiration date.
 - 2. Primary and secondary diagnosis.
 - 3. Contact person.
 - 4. Physician's name and address.
 - 5. The medical and other services to be provided, their frequency and duration and the name of the service provider chosen by the participant to provide each service.
 - 6. The name and title of the DAAS Rehab Counselor or RN responsible for the development of the participant's plan of care.
 - 7. Physician's signature (must be an original signature).
- C. The DAAS Rehab Counselor or RN will forward the plan of care to the participant's attending physician for approval and original signature. The plan of care must be approved and signed by the physician before services are rendered.
- D. A copy of the signed plan of care will be forwarded to the waiver participant and the service provider(s) chosen by the participant or the participant's legal representative if waiver eligibility is approved by the DHHS county office. The service provider and the Alternatives

participant must review and follow the signed authorized plan of care. The original plan of care will be maintained by the DAAS Rehab Counselor or RN.

- E. The implementation of the plan of care by a provider must ensure that services are:
1. Individualized to the participant's unique circumstances.
 2. Developed within a process assuring participation of those concerned with the participant's welfare.
 3. Monitored and adjusted to reflect changes in the participant's need.
 4. Provided in a way that safeguards the participant's rights.
 5. Documented carefully, with appropriate records maintained according to Medicaid policy regarding record retention.
- F. The DAAS Rehab Counselor or RN and the case manager are responsible for monitoring the participant's status on a regular basis for changes in service need, referring the participant for reassessment if necessary and reporting any participant complaints of violations of rules and regulations to the Director, Division of Medical Services. The provider is responsible for requesting all changes in services and reporting all changes in the participant's status or condition immediately upon learning of the change.
- NOTE: Revisions to a participant's plan of care may only be made by the DAAS Rehab Counselor or RN.**
- G. Each service must be provided in accordance with the participant's plan of care. As detailed in the Medicaid Program provider contract, providers may bill for services in the amount and frequency detailed in the participant's plan of care and only after services are rendered.

212.300 Temporary Absences From the Home

7-1-07

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 DAAS Rehab Counselor or RN 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 participant 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 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the DAAS Rehab Counselor or RN 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 participant has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of admission, but the Medicaid case will be left open. When the participant returns home, the waiver case may be reopened effective the date the participant returns home.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment

to the hospital begins on the date of admission. Payment to the hospital does not include the date of discharge.

If Attendant Care Services are billed on the same day the waiver participant is admitted to the hospital or any other inpatient facility, Attendant Care Services are not billable. If Attendant Care services are provided on the same day the waiver participant comes home from the inpatient facility, Attendant Care Services are billable.

All payments for waiver services provided during an inpatient stay will be subject to Recoupment. Recoupments will include the date of admission.

When a waiver participant is absent from the home for reasons other than institutionalization, the DHHS county office will not be notified unless the participant does not return home within 30 days. If, after 30 days, the participant has not returned home and the providers can no longer deliver services as prescribed by the plan of care (e.g., the participant has left the state and the return date is unknown), the DAAS Rehab Counselor or RN 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 participant's absence.

212.400 Reporting Changes in Participant's Status

7-1-07

Because the provider has more frequent contact with the participant, the provider may become aware of changes in the participant's status sooner than the DAAS Rehab 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 DAAS Rehab Counselor or RN. A copy must be retained in the provider's participant case record. Whether the change may or may not result in action by the DHHS county office, providers must report all changes in the participant's status to the DAAS Rehab Counselor or RN.

213.000 Description of Services

213.100 Environmental Accessibility Adaptations/Adaptive Equipment

7-1-07

Environmental Accessibility Adaptations/Adaptive Equipment Services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise.

- A. Environmental Accessibility Adaptations/Adaptive Equipment Services are physical adaptations to the Alternatives Waiver participant's place of residence that are necessary to:
 - 1. Ensure the health, welfare and safety of the individual.
 - 2. Enable the individual to function with greater independence in the home.
 - 3. Preclude or postpone institutionalization.
- B. Adaptations may include the installation and/or regular repair of ramps and grab-bars, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing systems or vehicle modifications that are necessary for the welfare of the individual.
 - 1. Adaptations must be as listed in the plan of care and in accordance with all applicable state or local building codes.
 - 2. Only licensed (where applicable), certified individuals may install, build, service, repair or modify environmental adaptations paid for by Medicaid.

- C. Excluded are adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. If adaptations are made to rental property, it is the responsibility of the participant and the DAAS Rehab Counselor or RN to obtain written permission from the property owner before including the adaptation in the plan of care.
- D. Refer to Section 242.100 of this manual for the procedure code to be used when filing claims for this service.

213.110 Benefit Limit - Environmental Accessibility Adaptations/Adaptive Equipment

7-1-07

The overall cap for Environmental Accessibility Adaptations/Adaptive Equipment is \$7,500 per the lifetime of the eligible Alternatives waiver participant. If a waiver participant is receiving Environmental Accessibility Adaptations and Adaptive Equipment, the combined cost cannot exceed the \$7,500 overall cap. A waiver participant may access through the waiver several occurrences of Environmental Accessibility Adaptations or for several items of Adaptive Equipment over a span of years, or he/she may access the whole \$7,500 at one time. Once the \$7,500 per eligible participant is reached, no further Environmental Accessibility Adaptations/Adaptive Equipment can be accessed through the waiver by the eligible waiver participant during his/her remaining lifetime. As with any Medicaid program, when the maximum benefit limit has been reached, the waiver participant will have to access funding from other sources, if additional Environmental Accessibility Adaptations/Adaptive Equipment services are needed. DAAS has established internal procedures to assist eligible waiver participants who have exhausted their benefit for this service.

213.200 Attendant Care Service

7-1-07

Attendant Care Service is assistance to a medically stable, physically disabled participant in accomplishing tasks of daily living that the participant is unable to complete independently. Assistance may vary from actually doing a task for the participant, to assisting the participant to perform the task or to providing safety support while the participant performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished. Housekeeping activities as described above may not exceed 20% of the Attendant's overall time worked as authorized on the waiver plan of care. Attendant Care Services may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care services, accompanying a participant to assist with shopping, errands, etc.

- A. If Attendant Care Service is selected, a consumer-directed approach will be used in the provision of Attendant Care services. The participant is free to select the tasks to be performed and when these tasks will be accomplished. Each participant who elects to receive Attendant Care Services must agree to and be capable of recruiting, hiring, training, managing and terminating Attendants. The participant must also monitor Attendant Service timesheets and approve payment to the Attendant for services provided by signing the timesheets.

Participants 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 participant's plan of care will be submitted to the attending physician for his or her review and approval.
- B. The Evaluation of Need for Nursing Home Care Form (DHHS-703) completed by the DAAS Rehab Counselor or RN for each Alternatives Waiver applicant will contain information relative to the participant's functional, social and environmental situation.

- C To aid in the Attendant Care recruitment process, participants will be apprised of the minimum qualifications set forth for provider certification (See section 213.220) and the Medicaid enrollment and reimbursement process. The participant will be instructed to notify the DAAS Rehab Counselor or RN when an attendant has been recruited. The DAAS Waiver Counselor or RN will facilitate the development of a formal service agreement between the participant and the Attendant, using the form AAS-9512, Attendant Care Service Agreement. Instructions are provided with the Attendant Care packet.
- D When the AAS-9512, Attendant Care Service Agreement, is finalized, the Attendant will apply for DAAS certification and Medicaid provider enrollment. The DAAS Rehab Counselor or RN or designee 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.

Service agreements and required tax documents do not transfer from one waiver client to another or from one waiver provider to another. All service agreements and tax forms are specific to each employer and employee working arrangement.
- E. Refer to section 243.100 of this manual for the procedure code to be used with filing claims for this service.

213.210 Tasks Related to Attendant Care Services

7-1-07

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

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

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

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

- The Alternatives participant is mentally capable of understanding what medications he or she is taking.
- The Alternatives participant is mentally capable of understanding the purpose of taking the medication and when the medication must be taken.

- The Alternatives participant's physical limitations prevent him or her from getting the medication out of its container and getting it into his or her mouth.

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

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

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

Housekeeping: Incidental housekeeping means cleaning of the floor and furniture ONLY in the room, space or location occupied by the Alternatives participant; for example, the participant's bedroom. Incidental housekeeping is hands-on assistance with waiver-covered tasks that the participant cannot physically perform himself or herself. This does not mean cleaning the whole house. If the participant lives in a house with other household members, housework for the other members of the household is not allowed as part of the Alternatives waiver services.

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

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

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

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

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

213.220 Benefit Limit - Attendant Care

7-1-07

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

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

213.230 Provider Qualifications - Attendant Care Services

7-1-07

Eligible Alternatives participants may establish an Alternatives Attendant Care Service Agreement, AAS-9512, with individuals who meet the following criteria:

- A. The Attendant Care provider shall not be an individual who is considered legally responsible for the participant, e.g., spouse or guardian or anyone acting as a guardian.
- B. The Attendant Care provider must be 18 years of age or older.
- C. The Attendant Care provider must be a United States citizen or legal immigrant authorized to work in the U.S.
- D. The provider of Attendant Care Services must be free from evidence of the following:
 - 1. Abuse or fraud in any setting
 - 2. Violations in the care of a dependent population
 - 3. Conviction of a crime related to a dependent population
 - 4. Conviction of a violent crime
- E. The Attendant Care provider must be able to read and write at a level sufficient to follow written instructions and maintain records.*
- F. The Attendant Care provider must be able to do simple math in order to complete billing claim forms.*
- G. The Attendant Care provider must be in adequate physical health to perform the job tasks required.
- H. The Attendant Care provider must be free from diseases transmittable through casual contact.

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

213.300 Agency Attendant Care

7-1-07

Agency Attendant Care services is the provision of assistance to a medically stable and/or physically disabled person to accomplish those tasks of daily living that the individual is unable to complete independently and that are performed by an Attendant Care employee hired by an agency selected by the waiver participant. Assistance may vary from actually doing a task for

the individual to assisting the individual with the task or to providing safety support while the individual performs the task. Housekeeping activities that are incidental to the performance of care may also be furnished. Housekeeping activities as described above may not exceed 20% of the attendant’s overall time worked as authorized on the waiver plan of care. Agency Attendant Care Services may also include supervision, companion services, socialization, and transportation assistance when it is incidental to providing Attendant Care Services while accompanying a participant to assist with shopping, errands, etc.

If agency Attendant Care Services are selected, participants may choose to have their services provided through an agency that is certified by the Division of Aging and Adult Services to provide Agency Attendant Care. When the participant chooses to have Attendant Care Services provided through an agency, the participant may choose one of two agency Attendant Care Services options: 1) participant/co-employer where the participant functions as the co-employer (managing employer) of employees hired by an Attendant Care agency, and the agency manages the hiring and fiscal responsibilities or 2) a traditional agency model for Attendant Care Services where the agency performs both the managing of the Attendant Care employee and hiring and fiscal responsibilities.

A. If the participant chooses the participant/co-employer (managing employer) option, the participant performs duties such as determining the Attendants’ duties consistent with the service specification in the approved plan of care, scheduling Attendants, orienting and instructing Attendants’ duties, supervising Attendants, evaluating Attendants’ performance, verifying time worked by Attendants, approving time sheets and discharging Attendants from providing services. The participant may also recruit prospective Attendant Care Aides who are then referred to the agency for consideration for hiring. The agency chosen by the participant to provide Attendant Care Services is the employer of participant-selected/recruited staff and performs necessary payroll and human resources functions.

If the participant chooses the traditional agency model option, the agency performs both the responsibilities of managing the Attendant Care employee and the hiring and fiscal responsibilities. Participants who decide to have their Attendant Care services provided through an agency may wish to have Alternatives Agency Attendant Care Services included on their plan of care. The participant’s plan of care is submitted to the participant’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 DAAS Rehab Counselor or RN for each Alternatives Waiver applicant contains information relative to the participant’s functional, social and environmental situation.

C. The Attendant Care agency must staff and notify the DAAS Rehab Counselor or RN via the DAAS-9510, according to established program policy, when an Attendant has been assigned to a waiver participant. In addition, prior to Medicaid reimbursement, an agency must secure a service agreement, signed by the agency representative and the waiver participant. This agreement must be sent to the DAAS Central Office prior to claims submission.

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

E. Refer to section 244.100 of this manual for the procedure code to be used when filing claims for this service.

213.310 Tasks Related to Agency Attendant Care 7-1-07

See Section 213.210 for tasks related to Agency Attendant Care.

213.320 Benefit Limit – Agency Attendant Care 7-1-07

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

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

213.330 Provider Qualifications Agency Attendant Care

7-1-07

Class A or Class B Home Health Agencies licensed by the Arkansas Department of Health and Human Services to provide personal care and enrolled in the Arkansas Medicaid Program as a personal care provider may apply to enroll as a Medicaid Alternatives Agency Attendant Care provider.

Private Care agencies licensed by the Arkansas Department of Health and Human Services to provide personal care and enrolled in the Arkansas Medicaid Program as a personal care provider may apply to enroll as a Medicaid Alternatives Agency Attendant Care provider.

213.400 Covered Case Management /Counseling Support Services

7-1-07

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

- Orientation to the concept of consumer-direction
 - Providing skills training on how to recruit, interview, hire, evaluate, manage or dismiss Attendants
 - Providing support services
 - Assessing the individual's service needs to assist in accessing services that currently may or may not be in place. This does not refer to a medical assessment or replace any eligibility requirements for any Medicaid program
 - Routinely monitoring Alternatives participants' needs, employer status, and circumstances and reporting findings according to program policy to DAAS
 - Providing management reports to DAAS
 - Reporting changes and required information to DAAS, as required by policy
 - Attending training as provided or required by DAAS
 - Referring the waiver participant to resources to assist in meeting their needs
 - Scheduling appointments related to gaining access to medical, social, educational and other services appropriate to the participant's needs. This includes, but is not limited to, medical appointments, transportation services and appointments with DHHS.
 - Performing face to face or telephone contacts with the participant and/or other individuals for the purpose of assistance in meeting the participant's needs
 - Assisting a waiver participant in completing the application for types of assistance
 - Conferencing with others, on behalf of the applicant, to assist in the application process for accessing services
 - Referring waiver participant for community resources, such as energy assistance, legal assistance, emergency housing
-

- Training Attendant Care provider in proper billing procedures
- Explaining APD program policy and monitoring compliance
- Securing 3 separate bids for environmental modifications/adaptive equipment service as required by policy. If the case manager is an employee of a provider type 84 that is submitting a bid to provide a waiver service, the case manager may not assist the waiver participant in securing the other two required bids.

214.000 Documentation in Participant Files

7-1-07

Documentation in the case file must support all activities for which Medicaid is billed.

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

- A copy of the waiver participant's AAPD plan of care
- A brief description of the specific services rendered
- The type of service rendered: assessment, service management and/or monitoring
- The type of contact: face to face or telephone
- The date and actual clock time for the service rendered, including the start time and stop time for each service
- The participant's name and Medicaid number
- The name of the person providing the service. The case manager providing the service must initial each entry in the case file. If the process is automated and all records are computerized, no signature is required. However, there must be an agreement or process in place showing the responsible party for each entry.
- The place of service (where the service took place: e.g. office, home)
- Updates describing the nature and extent of the referral for services delivered
- Description of how case management and other in-home services are meeting participant's needs
- Progress notes on participant's conditions, whether deteriorating or improving and the reasons for the change
- Process for tracking the date the participant is due for reevaluation by the Division of County Operations. The tracking is to avoid a participant's case from being closed unnecessarily
- The agency may establish a tickler system that meets the requirements of the program.

Documentation, as described above, is required each time a Case Management or Counseling function is provided for which Medicaid reimbursement will be requested.

215.000 Record Keeping Requirements

7-1-07

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

- A. The provider must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with any Medicaid participant.
- B. Providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.
- C. The provider must maintain a copy of each relevant prescription in the Medicaid participant's records and follow all prescriptions and care plans.
- D. Providers must adhere to all applicable professional standards of care and conduct.
- E. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary.
 - 1. All documentation must be available at the provider's place of business.
 - 2. When records are stored off-premise or are in active use, the provider may certify in writing that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.
 - 3. If an audit determines that recoupment is necessary, there will be no more than thirty (30) days after the date of the recoupment notice in which additional documentation will be accepted.

215.100 Requirements for Time Records and the Tickler System

7-1-07

Each Case Manager (CM) must maintain a tickler system for tracking purposes.

- A. The tickler system must track and notify the CM of the following activities:
 - 1. Each active participant in the case manager's caseload
 - 2. Date Case Management/Counseling Services began
 - 3. Expiration date of any Medicaid waiver plan of care applicable to a given participant
 - 4. Medicaid eligibility date and waiver eligibility date
 - 5. The participant's case reevaluation date, as established by DHHS, Division of County Operations
 - 6. Name, address and telephone number of each Attendant or Agency providing Attendant Care Services to waiver participant
- B. It is the responsibility of the Case Manager to maintain a tickler system as described above for those beneficiaries in their specific caseload. However, the record keeping requirements and documentation requirements must be maintained in the participant's file.

216.100 Assessment/Service Plan Development

7-1-07

This component is an annual face-to-face contact with the participant and contact with other professionals, caregivers or other parties on behalf of the participant. Assessment is performed

for the purpose of collecting information about the recipient's situation and functioning and to determine and identify the recipient's problems and needs.

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

- A. The assessment of an eligible individual to determine the need for any medical, educational, social and other services. Specific assessment activities include:
 - 1. Taking participant history
 - 2. Identifying the needs of the participant
 - 3. Completing related documentation
 - 4. Gathering information from other sources, such as family members, medical providers and educators, if necessary, to form a complete assessment of the Medicaid eligible individual
- B. An assessment may be completed between annual assessments, if the CM deems it necessary.
 - 1. Documentation in the participant's case file must support the assessment, such as life-changing diagnoses, major changes in circumstances, death of a spouse, change in primary caregiver, etc.
 - 2. Any time an assessment is completed, the circumstances resulting in a new assessment rather than a monitoring visit must be documented and must support this activity.
- C. Service plan development builds on the information collected through the assessment phase and includes ensuring the active participation of the Medicaid-eligible individual. The goals and actions in the care plan must address medical, social, educational and other services needed by the Medicaid-eligible individual. Service plans must:
 - 1. Be specific and explain each service needed by the participant.
 - 2. Include all services, regardless of payment source.
 - 3. Include support services available to the participant from family, community, church or other support systems and what needs are met by these resources.
 - 4. Identify immediate, short term and long term ongoing needs as well as how these needs/goals will be met.
 - 5. Assess the participant's individualized need for services and identify each service to be provided along with goals.
- D. The assessment and the service plan may be accomplished at the same time, during the same visit, or separately.

216.200 Service Management/Referral and Linkage

7-1-07

This component includes activities that help link Medicaid eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.

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

216.300 Service Monitoring/Service Plan Updating

7-1-07

This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid individual.

- A. The activities and contacts may be with the Medicaid eligible individual, family members, providers or other entities.
- B. They may be as frequent as necessary, but no less than once a month, to help determine such things as:
 1. Whether services are being furnished in accordance with a Medicaid eligible individual's plan of care
 2. The adequacy of the services in the plan of care
 3. Changes in the needs or status of the Medicaid eligible individual
- C. Monitoring is allowed through regular contacts with service providers at least once a month for the first 6 months of certification and at least every other month thereafter to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the participant, at least monthly, that the participant continues to participate in the service plan and is satisfied with services.
 1. A face to face monitoring contact with the waiver participant must be completed monthly for the first 6 months of participation in the APD program and then once every other month thereafter.
 2. A contact is not considered a covered monitoring contact unless the required monitoring form is completed, dated, signed by the Case Manager and filed in the participant's case file.
- D. Updating includes:
 1. Reexamining the participant's needs
 2. Identifying changes that have occurred since the previous assessment
 3. Altering the service plan
 4. Measuring the participant's progress toward service plan goals. Service plans should not be updated more than quarterly unless there is a significant change in the participant's needs.

216.400 Support of Financial Management Services

7-1-07

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

216.500 Counseling Support

7-1-07

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

participant and is covered extensively in training prior to any Case Manager being assigned an APD participant.

216.510 Benefit Limit – Case Management/Counseling Support 7-1-07

One unit of Case Management/Counseling Support equals one month of service. The established benefit limit for Alternatives Case Management is twelve (12) months per SFY. Services are reimbursable when provided according to the participant’s approved plan of care and according to established DAAS policy. All required components, tasks, services and support described in this manual and provided to case management providers either in writing or verbally through DAAS training classes are a part of the overall monthly CM/CS service. The monthly service varies depending on the needs of the waiver participant.

219.000 Client Appeal Process 7-1-07

When Alternatives for Adults with Physical Disabilities Waiver services are denied, the participant 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.](#)

240.000 BILLING PROCEDURES

241.000 Introduction to Billing 7-1-07

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

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

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

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

241.100 Alternatives Waiver Procedure Codes 7-1-07

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

Procedure Code	Modifier	Description
S5165		Environmental Accessibility Adaptations/Adaptive Equipment
S5125		Attendant Care
S5125	U1	Agency Attendant Care, Co-Employer
S5125	U2	Agency Attendant Care, Traditional

Procedure Code	Modifier	Description
T2020		Case management/Counseling Support

242.000 Billing Instructions 7-1-07

Use the CMS-1500 to bill for agency Attendant Care, case management, or environmental accessibility adaptations/adaptive equipment services.

Use the AAS-9559 (Alternatives Attendant Care Provider Claim Form) to bill for consumer-directed Attendant Care.

242.100 CMS-1500 Billing Procedures 7-1-07

EDS offers providers several options for electronic billing. Providers of Environmental Accessibility Adaptations/Adaptive Equipment Services may bill electronically or on paper.

242.110 CMS Billing Procedures 7-1-07

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.](#)

242.200 Alternatives Consumer-Directed Attendant Care Provider Claim Form (AAS-9559) Billing Instructions 7-1-07

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

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

242.201 Completion of Alternatives Attendant Care Provider Claim Form AAS-9559 7-1-07

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

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

The participant information at the top of the AAS-9559 billing claim form is completed by the Alternatives Counselor or RN.

The Attendant Care Aide provider and the waiver participant must sign and date the AAS-9559 claim form. If both signatures are not included, the claim form will be returned and payment will be delayed. Original signatures only are accepted on the billing claim form. Do not fax

AAS-9559 claim forms to the Alternatives Office or to EDS. The AAS-9559 claim form must be mailed to:

EDS Federal Corporation
 DAAS Claims
 P O Box 709
 Little Rock, AR 72203

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

7-1-07

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: An Attendant Care provider who provides services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

Regardless of the date that Attendant Care services begin for an Alternatives participant, Medicaid reimbursement is not allowed prior to the latter of the following:

- The date the Alternatives participant’s waiver eligibility begins
- The date the provider is eligible to provide Attendant Care Services, as certified by DAAS
- The date that both the Attendant Care provider and the Alternatives participant sign the Alternatives Attendant Care Service Agreement (AAS-9512)

The Attendant Care provider’s DAAS certification effective date will be the latter of:

- The waiver eligibility effective date of the Alternatives participant
- The date the Alternatives Attendant Care Service Agreement (AAS-9512) is signed by the Attendant Care provider and the Alternatives participant.

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

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

- The Attendant Care Service Agreement (AAS-9512) cannot be back dated.
- Once signed and dated by the provider and the waiver participant, the Attendant Care Service Agreement (AAS-9512) must be postmarked within 14 calendar days of the signatures on the agreement.

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

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

EDS Federal Corporation
 Provider Enrollment Unit
 PO Box 709
 Little Rock, AR 72203-0709
 (501) 376-2211 or 1-800-457-4454

If an Attendant Care provider quits working for an Alternatives participant, the DAAS Rehab Counselor or RN must be notified immediately in writing.

242.300 Special Billing Procedures

242.310 Attendant Care Services

7-1-07

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.

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

Regardless of the number of waiver participants for whom an Attendant Care provider works, no more than 12 hours per day are eligible for reimbursement consideration by the Arkansas Medicaid program. In addition, if an Attendant Care provider is employed by another waiver participant OR another employer, all hours of employment will be considered when authorizing Attendant Care services for a waiver participant. No more than a total of 12 hours/day including ALL employment, will be allowed for an Attendant Care provider.

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

242.311 Agency Attendant Care Services

7-1-07

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

242.320 Environmental Modifications/Adaptive Equipment

7-1-07

Prior to payment for this service the waiver participant is required to secure 3 separate itemized bids for the same service. The bids are reviewed by the DHHS Rehab Counselor, DHHS RN or designee prior to submission for Medicaid payment.

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