Arkansas Department of Health and Human Services

Division of Medical Services

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

DATE: **December 15, 2005**

SUBJECT: **Provider Manual Update Transmittal #56**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	12-15-05
212.200 – 212.313	Dates vary	212.200 – 212.313	12-15-05
212.320 – 212.322	6-1-05	212.320 – 212.322	12-15-05
212.400 – 212.500	Dates vary	212.400 – 212.500	12-15-05
213.110	10-13-03	213.110	12-15-05
213.210 – 213.220	6-1-05	213.210 – 213.220	12-15-05
213.300	6-1-05	213.300	12-15-05
213.311 – 213.321	Dates vary	213.311 – 213.321	12-15-05
213.323	6-1-05	213.323	12-15-05
213.340	6-1-05	213.340	12-15-05
213.500 – 213.711	Dates vary	213.500 – 213.711	12-15-05
215.000	10-13-03	215.000	12-15-05
262.100 – 262.200	Dates vary	262.100 – 262.200	12-15-05

Explanation of Updates

Throughout the manual, the name of the Department of Human Services has been changed to the Department of Health and Human Services; the acronym referring to the office has been changed to DHHS. Grammatical corrections and rewording of the policy for clarity purposes occur in various sections in addition to the changes for the following sections:

Section 201.000: This section has been revised and reformatted. The provider participation and enrollment procedures have been updated.

Section 212.200: A grammatical error was corrected.

Section 213.300: The modifier for procedure code **S5170**, Emergency Home-Delivered Meal, has been changed back to **U1**.

Sections 213.311 and 213.323: A reference to the Health Department has been changed to the Division of Health.

Section 213.500: This section is being issued to correct information in the policy regarding Adult Day Care services. Specifically, the unit of services is corrected to show fifteen (15) minutes.

Sections 213.710 through 213.711: Obsolete information has been deleted from this section.

Section 262.100: The information in the HCPCS Procedure Codes table has been updated. The **U1** modifier has been added for procedure code **S5170**, Emergency Home-Delivered Meal, and the place of service codes for various procedure codes have been updated.

Section 262.200: The information in this table has been updated. Under the electronic claims column, the place of service code for a Day Care Facility has been changed to code "99."

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.

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Roy Jeffus, Director

201.000 Arkansas Medicaid Certification Requirements for ElderChoices H&CB Waiver Program 12-15-05

All ElderChoices home and community-based (H&CB) waiver providers must meet the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. ElderChoices H&CB Waiver providers 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 service(s) they wish to enroll to provide.

B. The provider must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). A copy of the current certification must accompany the provider application and Medicaid contract. Subsequent certification renewals must be submitted upon receipt. **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).**

Certification by the Division of Aging and Adult Services does not guarantee enrollment in the Medicaid program.

C. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. 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.

All providers must maintain their provider files at the Division of Medical Services (DMS) by submitting current certification, licensure, etc., all DAAS-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider. Failure to submit required documents will result in termination of the provider's eligibility for reimbursement of services. Providers may avoid a cancellation of provider eligibility by timely submission of required materials to the Medicaid Provider Enrollment Unit. **View or print the Provider Enrollment Unit contact information.**

Copies of certifications and renewals required by DAAS must be maintained by DAAS to avoid loss of provider certification. These copies must be submitted to DAAS ElderChoices Provider Certification. **View or print the Division of Aging and Adult Services ElderChoices Provider Certification contact information.**

212.200 Level of Care Determination 12-15-05

The intermediate level of care determination is performed by medical staff assigned to the Department of Health and Human Services (DHHS) Utilization Review Team. The intermediate level of care criteria provide an objective and consistent method for evaluating the need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance to nursing home admission criteria, must be completed and the individual deemed eligible for an intermediate level of care by a licensed medical professional prior to receiving ElderChoices services.

Reevaluations will be performed annually by the Department of Health and Human Services team to determine the client's continuing need for an intermediate level of care. The results of the level of care determination and the reevaluation are documented on form DHS-704.

212.300 Plan of Care 12-15-05

Each client eligible for ElderChoices must have an individualized plan of care. The authority to develop an ElderChoices plan of care is given to the Medicaid State Agency's designee, the Department of Health and Human Services Registered Nurse (DHHS RN). The ElderChoices plan of care developed by the DHHS RN supersedes all other plans of care developed for an ElderChoices client. The information in the plan of care must include:

A. Client identification information, including full name and address, date of birth, Medicaid number and effective date of ElderChoices waiver eligibility;

B. The medical and other services to be provided, their frequency and duration and the name of the service provider chosen by the client to provide each service;

C. A calculation of the services' cost effectiveness and

D. The name and title of the DHHS RN responsible for the development of the client's plan of care.

The DHHS RN will forward the plan of care to the client's attending physician for approval and signature. The comprehensive plan of care must be approved and signed by the physician before services may begin. Services may begin under a provisional plan of care that is not signed by the physician. See section 212.310.

A copy of the signed plan of care will be forwarded to the ElderChoices service provider(s) of the client's choice. Each provider is responsible for developing an implementation plan in accordance with the client's plan of care. The original plan of care will be maintained by the DHHS RN.

The implementation plan must be designed to ensure that services are:

A. Individualized to the client's unique circumstances;

B. Provided in the least restrictive environment possible;

C. Developed within a process ensuring participation of those concerned with the client's welfare;

D. Monitored and adjusted to reflect changes in the client's need;

E. Provided within a system that safeguards the client's rights and

F. Documented carefully, with assurance that appropriate records will be maintained.

NOTE: Each service included on the ElderChoices plan of care must be justified by the DHHS RN. This justification is based on medical necessity, the client's physical,

mental and functional status, other support services available to the client, cost effectiveness and other factors deemed appropriate by the DHHS RN.

REVISIONS TO A CLIENT'S PLAN OF CARE MAY ONLY BE MADE BY THE DHHS RN.

The DHHS RN is responsible for monitoring the client's status on a regular basis for changes in his or her service needs, referring the client for reassessment if necessary and reporting any client complaints of violations of rules and regulations to the Director, Division of Medical Services. The provider is responsible for reporting any changes in services or changes in the client's status immediately upon learning of the change.

Each ElderChoices service must be provided according to the client's plan of care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

NOTE: Once the plan of care is signed by the client's physician, all revisions must be authorized by the DHHS RN. A revised plan of care will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on an ElderChoices plan of care, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the ElderChoices plan of care are subject to recoupment.

212.310 Provisional Plan of Care 12-15-05

The ElderChoices registered nurse (DHHS RN) will develop a provisional plan of care, based on information obtained during the in-home medical assessment, when recommending medical approval based on the following nursing home criteria.

To be determined a functionally disabled elderly individual, the individual must meet at least one of the following criteria, as determined by a licensed medical professional. The individual is unable to perform either of the following:

A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person

B. At least two (2) of the three (3) ADLs of transferring/locomotion, eating or toileting without limited assistance from or total dependence upon another person

Applicable definitions of limited and extensive assistance remain unchanged.

The provisional plan of care will include all current plan of care information except for the waiver eligibility date, the Medicaid recipient ID number, the diagnosis(es) and the physician's signature.

The provisional plan of care will expire after 60 days. The provisional plan of care expiration date will be entered on page 1 of the plan of care and will be calculated as 60 days from the date the provisional plan of care is signed by the DHHS RN and the applicant.

A signed copy of the provisional plan of care will be mailed to each provider included on the plan of care. If the provider chooses to implement the provisional plan of care, the provider must begin services within an established time frame as determined by the Division of Aging and Adult Services and notify the DHHS RN via form AAS-9510 that services have started. The DHHS RN will continue the current practice of tracking the start of care dates and giving the applicant options when services are not started.

A. Services Begin Based on the Provisional Plan of Care

This change in policy will be applied only when the DHHS RN recommends the applicant for medical approval and only when the recommendation is based on the medical criteria shown above.

The waiver eligibility date will be established retroactively, effective on the day the provisional plan of care was signed by the applicant and the DHHS RN, if:

1. At least one waiver service begins within 30 days of the development of the provisional plan of care

   AND

2. The waiver application is approved by the Division of County Operations.

B. Services Do Not Begin Based on the Provisional Plan of Care

If at least one waiver service does not begin within 30 days of the date the provisional plan of care is signed by the DHHS RN, the DHHS county office will establish the waiver eligibility date as follows:

1. According to current policy, i.e., the date the application is keyed into the system as an approved application

   OR

2. Retroactively, effective on the day a waiver service started, as verified by the DHHS RN.

212.311 Denied Eligibility Application 12-15-05

A. If the DHHS county office denies the Medicaid eligibility application for any reason, Medicaid and waiver services provided during a period of ineligibility will be the financial responsibility of the applicant. The DHHS county office will notify the DHHS RN. The DHHS RN will notify the providers via form AAS-9511 immediately upon learning of the denial. Reasons for denial include but are not limited to:

1. Failure to obtain the physician's signature on the required ElderChoices forms
2. Failure to meet the nursing home admission criteria
3. Withdrawal of the application by the applicant
4. Death of the applicant when no waiver services were provided

NOTE: If waiver services were provided and the applicant dies prior to approval of the application, waiver eligibility will begin (if all other eligibility requirements are met) on the date waiver service(s) began and end on the date of death.

B. The client has the right to appeal by filing for a fair hearing. When an appeal ruling is made in favor of the applicant, the actions to be taken by the DHHS county office are as follows:

1. If the individual has no unpaid ElderChoices Waiver charges, Medicaid coverage will begin on the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHHS county office completes the case.
2. If the individual has unpaid waiver charges and services were authorized by the DHHS RN, eligibility for both Medicaid and waiver services will begin on the date service began unless the hearing decision sets a begin date.

NOTE: Under no circumstances will waiver eligibility begin prior to the date of application or the date the provisional plan of care is signed by the DHHS RN and the applicant, whichever is later.

212.312 Comprehensive Plan Of Care 12-15-05

Prior to the expiration date of the provisional plan of care, the DHHS RN will mail the comprehensive plan of care, signed by the applicant's physician, to all providers included on the plan of care. The comprehensive plan of care will replace the provisional plan of care. If the DHHS county office has approved the application, the comprehensive plan of care will include the Medicaid recipient ID number, the diagnosis(es), the waiver eligibility date established according to this revised policy and the comprehensive plan of care expiration date.

The comprehensive plan of care expiration date will be 365 days from the date of the DHHS RN's signature on form AAS-9503, the ElderChoices plan of care. If the application is still pending at the county office when the comprehensive plan of care is mailed to the providers, the waiver eligibility date and the Medicaid recipient ID number will not be included. Once the application is either approved or denied by the DHHS county office, the providers will be notified by the DHHS RN. The notification for the approval will be in writing via a plan of care that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

212.313 ElderChoices Applicants Leaving an Institution 12-15-05

The revised policy regarding retroactive eligibility applies to applicants entering the waiver program from the community and to applicants entering the program from an institution. The same process and the same policy determining the waiver eligibility date will apply to applications of each type.

EXCEPTION: No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a provisional plan of care is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

NOTE: For inpatients, if a waiver application is filed at the local DHHS county office prior to discharge AND if a provisional plan of care is developed by the DHHS RN prior to discharge, it may be possible to establish retroactive eligibility back to the date the applicant returned to his or her home if the applicant is ultimately found eligible for the program.

If no waiver application is filed and no medical assessment or provisional plan of care is completed by the DHHS RN prior to an applicant's discharge from an institution, retroactive eligibility will not be possible back to the date the applicant returned to his home.

Medical assessments and plans of care may be completed during a period of institutionalization; however, a discharge date must be scheduled. Since the purpose of the assessment and the plan of care is to depict the applicant's condition and needs in the home, premature assessments and plan of care development do not meet the intent of the program.

This policy applies to applicants leaving hospitals or nursing facilities.

212.320 Physician Authorization Of The ElderChoices Plan Of Care with Personal Care Services 12-15-05

The following applies to individuals receiving both personal care services and ElderChoices services.

A. The DHHS RN is responsible for developing an ElderChoices plan of care that includes both waiver and non-waiver services. Once developed, the plan of care is sent to the applicant's physician of choice for signature, authorizing the services listed.

B. If personal care services are included on the ElderChoices plan of care when the physician signs it and returns it to the DHHS RN, the signed ElderChoices plan of care will suffice as the "Physician Authorization" for services required in the Personal Care Program. The signature on the ElderChoices plan of care only replaces the need for the physician's signature authorizing personal care services. No other requirements under the Personal Care Program regarding the personal care service plan are modified. The personal care services plan is still required.

C. The ElderChoices plan of care is effective for one year, once signed by the physician. The authorization for personal care services, included on the ElderChoices plan of care, is also for one year from the date of the physician's signature, unless revised by the DHHS RN. This policy supersedes information currently found in the Arkansas Medicaid Personal Care provider manual.

This policy does not place the responsibility of developing a personal care service plan with the DHHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care provider manual.

212.321 Internal Procedures 12-15-05

A. If personal care services are not currently being provided when the DHHS RN develops the ElderChoices plan of care, the DHHS RN will determine if personal care services are needed. If so, the service, amount, frequency duration and the recipient's provider of choice will be included on the ElderChoices plan of care. After the physician signs the ElderChoices plan of care, a copy of the plan of care and a start of care form (AAS-9510) will be forwarded to the personal care provider, as is current practice for waiver services. The start of care form must be returned to the DHHS RN within 14 working days from mailing, or action may be taken by the DHHS RN to secure another personal care provider or to modify the ElderChoices plan of care. (The ElderChoices plan of care is dated per the date it is mailed.) Before the DHHS RN takes action to secure another provider or modify the plan of care, the applicant and/or family members will be contacted to discuss possible alternatives.

B. If the DHHS RN is aware that personal care services are currently being provided when the ElderChoices plan of care is developed, the DHHS RN will contact the personal care provider to obtain the amount of personal care services currently being provided. It is the personal care provider's responsibility to provide this information to the DHHS RN immediately upon receipt of the request. If this information is not received within five working days of the request, the DHHS RN will take necessary steps to submit the ElderChoices plan of care, as developed by the DHHS RN, to the physician for signature.

NOTE: It is the personal care provider's responsibility to place information regarding his or her presence in the home in a prominent location so that the DHHS RN will be aware that the provider is serving the applicant. Preferably, the provider will place the information atop the refrigerator or under the phone the applicant uses, unless the applicant objects. If so, the provider will place the information in a location satisfactory to the applicant, as long as it is readily available to and easily accessible by the DHHS RN.

C. The personal care service plan provided to the DHHS RN must meet all requirements as detailed in the personal care provider manual. These include, but are not limited to, the amount of personal care services, personal care tasks, frequency and duration. The DHHS RN will not alter the current number of personal care units unless a waiver plan of care cannot be developed without duplicating services or a change in services is necessary in order to establish eligibility. If personal care units must be altered, the DHHS RN will contact the personal care provider to discuss available alternatives prior to making any revisions. The ElderChoices plan of care and the required justification for each service remain the responsibility of the DHHS RN. Therefore, final decisions regarding services included on the ElderChoices plan of care rest with the DHHS RN.

212.322 Revisions when the Plan Of Care Contains Personal Care Services 12-15-05

Once the physician signs the ElderChoices plan of care, requested changes to the personal care services included in the plan of care may originate with the personal care RN or the DHHS RN, depending on the recipient's circumstances. The individual or agency requesting revisions to the personal care services on the ElderChoices plan of care is responsible for securing the required physician order authorizing the change before the ElderChoices plan of care is revised.

If authorization is secured by the DHHS RN, a copy of the revised ElderChoices plan of care and form AAS-9510 will be mailed to the personal care provider within ten working days of authorization by the physician. If authorization is secured by the personal care agency, a copy of the revised personal care service plan, signed by the physician, must be sent to the DHHS RN before the personal care provider implements any revisions. Once received, the ElderChoices plan of care will be revised accordingly, within ten days of its receipt, and a copy will be mailed to the personal care provider and the targeted case manager, if applicable. If any problems are encountered with implementing the requested revisions, the DHHS RN will contact the personal care provider to discuss possible alternatives. These discussions and the final decision regarding the requested revisions must be documented in the nurse narrative. The final decision, as stated above, rests with the DHHS RN.

212.400 Temporary Absences From the Home 12-15-05

Once an ElderChoices eligibility application has been approved, waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the county office will be notified immediately by the DHHS RN when waiver services are discontinued, and action will be initiated by the county office to close the waiver case. Providers will be notified by the DHHS RN.

212.410 Institutionalization 12-15-05

An individual cannot receive AAS/ACS waiver services while in an institution. However, the following policy will apply to active waiver cases when the individual is hospitalized or enters a nursing facility.

A. Hospitalization

When a waiver client enters a hospital, the DHHS county office will not take action to close the waiver case unless the client does not return home within 20 days from the date of admission. If the client has not returned home after 20 days, the DHHS RN will notify the county office via form DHS-3330 and action will be initiated by the county office to close the waiver case.

NOTE: It is the responsibility of the provider to notify the DHHS RN immediately via form AAS-9511 upon learning of a change in the client's status.

B. Nursing Facility Admission

When an ElderChoices client has entered a nursing facility and it is anticipated that the stay will be short, the waiver case will be closed effective the date of admission, but the Medicaid case may be left open until the DHHS county office is notified that the individual has returned home. When the individual returns home, the ElderChoices case may be reopened effective the date of the return home if the DHHS RN has provided the DHHS county office with a copy of Page 2 of the plan of care, showing the election of ElderChoices. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the client's admission to the facility.

NOTE: Nursing facility admissions, when referenced in this section, do not include ElderChoices clients admitted to a nursing facility to receive facility-based respite services.

212.420 Non-Institutionalization 12-15-05

When a waiver client is absent from the home for reasons other than institutionalization, the 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 DHHS RN will notify the county office and action will be taken by the county office to close the waiver case.

NOTE: It is the responsibility of the provider to notify the DHHS RN immediately via form AAS-9511 upon learning of a change in the client's status.

212.500 Reporting Changes in Client's Status 12-15-05

Because the provider has more frequent contact with the client, many times the provider becomes aware of changes in the client's status sooner than the DHHS RN or DHHS county office. It is the provider's responsibility to report these changes immediately so that proper action may be taken. Providers are required to complete form AAS-9511 and send it to the DHHS RN. A copy should be retained in the client's case record. Regardless of whether the

change will result in action by the DHHS county office, providers must immediately report all changes to the DHHS RN.

213.110 Adult Foster Care Certification Requirements 12-15-05

Enrollment as an ElderChoices Adult Foster Care provider requires certification by the Department of Health and Human Services, Division of Aging and Adult Services, as an Adult Foster Care Home.

An Adult Foster Care Home, for the purpose of the ElderChoices Program, does not include any house, institution, hotel or other similar living situation that supplies room and board only, room only, or board only.

As a condition of certification, each Adult Foster Care provider shall execute with and provide to each client an admission agreement specifying services to be provided, the client's cost for room and board, conditions and rules governing the client and grounds for termination of residency. Each Adult Foster Care provider will also be required to develop and maintain written program policies.

213.200 Homemaker/Chore Services 10-13-03

213.210 Homemaker Services 12-15-05

Procedure Code	Description
S5130	Homemaker Services

In-home services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible client's functioning in his or her own home.

Homemaker services provide basic upkeep and management of the home and household assistance, such as:

A. Menu planning,

B. Meal preparation,

C. Laundry,

D. Essential shopping and errands and

E. Simple household tasks.

Simple household tasks may include, but are not limited to, washing windows, cleaning ceiling fans and light fixtures, cleaning the refrigerator and washing inside walls.

Medically oriented personal care tasks are not included as a part of this service.

Homemaker services must be provided according to the client's written plan of care and must be prescribed by the client's attending physician.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the client's case record. See section 214.000 for additional documentation requirements.

One (1) unit of service equals 15 minutes. Homemaker services are limited to a maximum of 172 units per month.

An ElderChoices client who spends more than five (5) hours at an adult day care or adult day health care facility or who is receiving short-term, facility-based respite care will not be eligible for homemaker services on the same date of service unless authorized by the DHHS RN.

An ElderChoices client receiving long-term, facility-based respite care is not eligible for homemaker services on the same date of service.

213.220 Chore Services 12-15-05

Procedure Code	Description
S5120	Chore Services

Chore services provide heavy cleaning and/or yard and sidewalk maintenance only in extreme, specific and individual circumstances when lack of these services would make the home uninhabitable.

Chore services do not include small outside painting jobs, routine lawn mowing or trimming, raking or mulching of leaves for aesthetic purposes.

Chore services must be provided according to the client's written plan of care and must be prescribed by the client's attending physician.

When justified and included on the plan of care by the DHHS RN, the chore service must be specific, naming the chore authorized and the estimated amount of time for completion.

A brief description of the service(s) provided, including the signature and title of the individual rendering the service, must be documented in the client's case record. Family members of the client may not be reimbursed by Medicaid for chore services. Family members are not eligible for consideration as chore specialists. Section 214.000 contains information regarding additional documentation requirements.

One (1) unit of service equals 15 minutes. Chore services are limited to a maximum of 80 units per month.

An ElderChoices client who spends more than five (5) hours at an adult day care or adult day health care facility or who is receiving short-term, facility-based respite care will not be eligible for chore services on the same date of service unless authorized by the DHHS RN.

An ElderChoices client receiving long-term, facility-based respite care is not eligible for chore services on the same date of service.

213.300 Home-Delivered Meals 12-15-05

Procedure Code	Required Modifier	Description
S5170	U2	Hot Home-Delivered Meal
S5170	—	Frozen Home-Delivered Meal
S5170	U1	Emergency Home-Delivered Meal

213.311 Hot Home-Delivered Meal Certification Requirements 12-15-05

To be certified by the Division of Aging and Adult Services as a provider of hot home-delivered meal services, a provider must:

A. Be a nutrition service provider whose kitchen is approved by the Division of Health and whose meals provide one-third of the Recommended Daily Allowance as approved by a dietitian;

B. Comply with all federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food;

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

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

For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For home-delivered meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.

213.320 Frozen Home-Delivered Meals 12-15-05

The Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to one-third of the Recommended Dietary Allowances (as recommended for an adult male 55 years or older). The meals must comply with the Dietary Guidelines for Americans and with DAAS Nutrition Services Policy Number 206.

The goal of the Frozen Home-Delivered Meals service is to supplement, not replace, the Hot Home-Delivered Meal service by providing one daily nutritious meal to homebound persons at risk of being institutionalized who:

A. Reside in remote areas where daily hot meals are not available,

B. Choose to receive a frozen meal rather than a hot meal* or

C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

***NOTE: While the individual has freedom of choice regarding this service, it is the responsibility of the DHHS RN developing the plan of care to ensure the appropriateness of the service. A hot meal delivered daily remains the food service of choice, when available. Therefore, a frozen meal must be approved by the DHHS RN. The service must be written on the plan of care. If the individual responsible for developing the plan of care does not think the frozen meals are appropriate for the individual, other options will be considered. Those options include removing the home-delivered meal service rather than authorizing a frozen meal.**

213.321 Beneficiary Requirements for Frozen Home-Delivered Meals 12-15-05

In order to receive frozen home-delivered meals under the waiver, an individual must:

A. Be homebound, which is defined by the following requirements:

1. The person is normally unable to leave home,
2. Leaving home requires considerable and taxing effort by the individual and

3. Absences of the individual from home are infrequent, of relatively short duration, or attributable to the need to receive medical treatment.

B. Be unable to prepare some or all of his or her own meals or require a special diet and be unable to prepare it.

C. Have no other individual available to prepare his or her meals, and the provision of a frozen home-delivered meal is the most cost-effective method of ensuring a nutritionally adequate meal.

D. Have adequate and appropriate storage and be able to perform the simple tasks associated with storing and heating a frozen home-delivered meal or have made other appropriate arrangements approved by DAAS.

E. Have the provision of frozen meals included in the individual's plan of care, as developed by the appropriate DHHS RN.

Frozen home-delivered meals must be prescribed by the recipient's attending physician, as documented on the ElderChoices plan of care by the DHHS RN, and must be provided in accordance with the individual's written plan of care.

213.323 Frozen Home-Delivered Meal Provider Certification Requirements 12-15-05

Providers of hot home-delivered meals may choose to be providers of frozen meals also. In order to become approved providers of frozen meals, they must meet all applicable requirements of DAAS Nutrition Services Policy Number 206.

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

A. Be a nutrition service provider whose kitchen is approved by the Division of Health and whose meals are approved by a licensed dietitian who has verified by nutrient analysis that they provide one-third of the Recommended Dietary Allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, comply with the Dietary Guidelines For Americans, and comply with DAAS Nutrition Services Policy Number 206*

B. Comply with all federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food*

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

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

*For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For home-delivered meal providers located in bordering states, all requirements must meet their states' applicable laws and regulations.

E. Provide frozen meals that:

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

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

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

NOTE: Many manufacturers of frozen meals recommend not using a "toaster oven" because the temperature of these ovens will melt the plastic trays in which the food is packaged as well as the plastic seal covering the food. If appropriate, the frozen meal provider must place applicable instructions on the food container.

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

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

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

I. Notify the appropriate DAAS staff member immediately if:

1. There is a problem with delivery of service,
2. The individual is not consuming the meals or
3. A change in individual capacity is noted.

NOTE: Changes in service delivery must receive prior approval by the DAAS staff member who is responsible for the individual's plan of care. Requests must be submitted in writing to the DHHS RN. Any changes in the individual's circumstances must be reported to the DHHS RN via form AAS-9511.

J. Contact individuals either in person or by phone daily, Monday through Friday, to ensure the individual's safety and well being. This is not required for individuals receiving only the weekend Frozen Home-Delivered Meals service.

NOTE: This requirement DOES NOT apply to those ElderChoices clients whose ElderChoices plan of care includes homemaker services and/or personal care services at least 3 times per week.

Home-delivered meals, hot or frozen, shall be included in the individual's plan of care only when they are necessary to prevent the institutionalization of an individual.

Re-assessment of all individuals of waiver services shall be completed at least annually, using form AAS-9703 in a manner similar to the initial assessment process.

213.340 Combination of Hot and Frozen Home-Delivered Meals 12-15-05

In instances where the ElderChoices client wishes to receive a combination of hot and frozen meals, the DHHS RN shall evaluate the client's situation based on the criteria set forth in section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the DHHS RN may prescribe on the plan of care a combination of hot and frozen meals to be delivered.

213.500 Adult Day Care 12-15-05

Procedure Code	Required Modifier	Description
S5100	U1	Adult Day Care, 4-5 Hours Per Date of Service
S5100	—	Adult Day Care, 6-8 Hours Per Date of Service

Adult day care facilities are licensed by the Office of Long-Term Care (OLTC) to provide care and supervision to meet the needs of four (4) or more functionally impaired adults for periods of less than 24 hours but more than two (2) hours per day, in a place other than the clients' own homes.

ElderChoices clients may receive adult day care services for four (4) or more hours per day, not to exceed eight (8) hours per day, when the services are prescribed by the client's attending physician and provided according to the client's written plan of care. Adult day care services of less than four (4) hours per day are not reimbursable by Medicaid. Adult day care may be utilized up to forty (40) hours per week, not to exceed one hundred eighty-four (184) hours per month. One (1) unit of service equals fifteen (15) minutes.

As required, clients who are present in the facility for more than five (5) hours a day (procedure code **S5100**) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ElderChoices clients are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day care. Additionally, clients who attend an adult day care for more than five (5) hours are not eligible to receive homemaker or chore services on the same date of service unless authorized by the DHHS RN.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day care, adult day health care, or facility-based respite care for more than 5 hours. The time of day the client is receiving day care or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DHHS RN and/or DHHS audit staff and considered when determining any duplication in services for individuals participating in the ElderChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day care or facility-based respite services on a specific date of service.

If an ElderChoices client is receiving day care or **facility-based** respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to this individual. A home-delivered meal is not allowable on the same date of service. This is true **regardless of the total number of day care or respite hours provided**.

Adult day care providers are required to maintain a daily attendance log of participants. Section 214.000 contains information regarding additional documentation requirements.

213.510 Adult Day Care Certification Requirements 12-15-05

To be certified by the Division of Aging and Adult Services as a provider of adult day care services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by the OLTC as a long-term adult day care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Care Facility.

213.600 Adult Day Health Care (ADHC) 12-15-05

Procedure Code	Required Modifier	Description
S5100	TD, U1	Adult Day Health Care, 4-5 Hours Per Date of Service
S5100	TD	Adult Day Health Care, 6-8 Hours Per Date of Service

Adult day health care facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to individuals who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health care programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the client that cannot be provided by adult day care programs. Adult day health care is appropriate only for individuals whose facility-developed care plans specify one or more of the following health services:

A. Rehabilitative therapies (e.g., physical therapy, occupational therapy),

B. Pharmaceutical supervision,

C. Diagnostic evaluation or

D. Health monitoring.

ElderChoices clients may receive adult day health care services for four (4) or more hours per day, not to exceed eight (8) hours per day when the service is prescribed by the client's attending physician and provided according to the client's written plan of care. Adult day health care services of less than four (4) hours per day are not reimbursable by Medicaid. Adult day health care may be utilized up to forty (40) hours (160 units) per week, not to exceed one hundred eighty-four (184) hours (736 units) per month.

Clients who are present in the facility for more than five (5) hours a day (procedure code **S5100**, modifier **TD**) must be served a nutritious meal that equals one-third of the Recommended Daily Dietary Allowances. Therefore, ElderChoices clients are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health care. Additionally, clients who attend an adult day health care for more than five (5) hours are not eligible to receive homemaker or chore services on the same date of service unless authorized by the DHHS RN.

Adult day health care providers are required by licensure to maintain a daily attendance log of participants. See section 214.000 for additional documentation requirements.

NOTE: As stated in this manual, home-delivered meals may not be provided on the same day for an individual who attends adult day care, adult day health care, or facility-based respite care for more than 5 hours. The time of day the client is receiving day care or respite services is also a factor in the application of this policy. The time of day services are received will be reviewed by the DHHS RN and/or DHHS audit staff and considered when determining any duplication in services for individuals participating in the ElderChoices Program.

Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day care or facility-based respite services on a specific date of service.

If an ElderChoices client is receiving day care or facility-based respite between the hours of 11:00 a.m. and 1:30 p.m. and the noon meal is routinely served to others at the facility during this time frame, the noon meal must also be served to the individual. A home-delivered meal is

not allowable on the same date of service. **This is true regardless of the total number of day care or respite hours provided.**

213.610 Adult Day Health Care Provider Certification Requirements 12-15-05

To be certified by the Division of Aging and Adult Services as a provider of adult day health care services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by Arkansas Department of Health and Human Services, Office of Long-term Care as a long-term adult day health care facility. Providers in the designated trade area cities in states that border Arkansas must be licensed and/or certified by the appropriate state agency as an Adult Day Health Care Facility.

NOTE: Adult day care and adult day health care are not allowed on the same date of service.

213.700 Respite Care 12-15-05

Procedure Code	Description
T1005	Long-Term Facility-Based Respite Care
S5135	Short-Term Facility-Based Respite Care
S5150	In-Home Respite Care

Respite care services provide temporary relief to persons providing long-term care for clients in their homes. Respite care may be provided in or outside of the client's home to meet an emergency need or to schedule relief periods in accordance with the regular caregiver's need for temporary relief from continuous caregiving. If there is no primary caregiver, respite care services will not be deemed appropriate and subsequently will not be prescribed by the client's physician.

In the event the in-home medical assessment performed by the DHHS RN substantiates a need for respite care services, the service will be prescribed as needed, via the client's plan of care, not to exceed an hourly maximum. The DHHS RN will establish the service limitation based on the client's medical need and the dollar amount available after calculating the client's total plan of care costs. Respite care services must be prescribed by the client's attending physician and must be provided according to the client's written plan of care.

213.710 In-Home Respite Care 12-15-05

In-home respite care may be provided by licensed personal care or home health agencies and certified homemaker agencies. Reimbursement will be made for direct care rendered according to the client's plan of care by trained respite workers employed and supervised by certified in-home respite providers.

Providers rendering respite care services in the client's home must bill procedure code **S5150**. One (1) unit of service for procedure code **S5150** equals 15 minutes. Eligible clients may receive up to 96 units of in-home respite care per date of service, not to exceed 2,400 units per state fiscal year. This benefit limit is separate from the benefit limit established for facility-based respite care services.

When respite care is provided, the provision of or payment for other duplicate services under the waiver is prohibited. When a respite care provider is in the home to provide respite care services, the provider is responsible for all other in-home ElderChoices services included on the client's plan of care. For example, if homemaker, chore and/or home-delivered meals (meal preparation) are included on the plan of care, the respite provider must provide these services while in the home. No other ElderChoices service, other than PERS, may be reimbursed for the

same time period. This policy does not prohibit other ElderChoices services on the same date of service as respite care.

213.711 Facility-Based Respite Care 12-15-05

Facility-based respite care may be provided outside the client's home on a short- or long-term basis by licensed adult foster care homes, residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities and hospitals.

Facility-based providers rendering services for eight (8) hours or less per date of service must bill **S5135** for short-term, facility-based respite care. One (1) unit of service for procedure code **S5135** equals 15 minutes. Eligible clients may receive up to 32 units of short-term, facility-based respite care per date of service.

Facility-based providers rendering services for twenty-four (24) hours per date of service must bill **T1005** for long-term, facility-based respite care. One (1) unit of service for procedure code **T1005** equals 15 minutes. Providers must render provide 96 units of service per date of service in order to bill procedure code **T1005**.

The benefit limit for facility-based respite care services is 2,400 units occurring from July 1 to June 30 of any state fiscal year. This benefit limit is inclusive of procedure code **S5135** or **T1005** or any combination of the two. Facility-based respite care services include short-term and long-term respite care services.

Clients receiving long-term, facility-based respite care services may only receive ElderChoices PERS services concurrently.

Please refer to the NOTE found in section 213.500 regarding Home-Delivered Meals and facility-based respite services.

215.000 ElderChoices Forms 12-15-05

ElderChoices providers are required to utilize all program forms as appropriate and as instructed by the Division of Medical Services and the Division of Aging and Adult Services. These forms include but are not limited to:

A. Plan of Care — AAS–9503

B. Quarterly Monitoring — AAS–9506

C. Start Services — AAS–9510

D. Client Change of Status — AAS–9511

Providers may request forms AAS–9506 and AAS–9511 by writing to the Division of Aging and Adult Services. **View or print the Division of Aging and Adult Services contact information.**

Forms AAS–9503 and AAS–9510 will be mailed to the provider by the DHHS RN.

Instructions for completion and retention are included with each form. If you have questions regarding any ElderChoices form, please contact the DHHS RN in your area.

262.100 HCPCS Procedure Codes 12-15-05

The following procedure codes must be billed for ElderChoices Services:

Procedure Code	Required Modifier	Description	Unit of Service	POS for Paper Claims	POS for Electronic Claims
S5100	—	Adult Day Care, 6 to 8 hours per date of service	15 min	5	99
S5100	U1	Adult Day Care, 4 or 5 hours per date of service	15 min	5	99
S5100	TD	Adult Day Health Care, 6 to 8 hours per date of service	15 min	5	99
S5100	TD, U1	Adult Day Health Care, 4 or 5 hours per date of service	15 min	5	99
S5120	—	Chore Services	15 min	4	12
S5130	—	Homemaker Services	15 min	4	12
S5135	—	Respite Care – Short-Term Facility-Based	15 min	5, 1, 7	99, 21, 33
S5140	—	Adult Foster Care	1 day	0	99
S5150	—	Respite Care – In-Home	15 min	4	12
S5160	—	Personal Emergency Response System – Installation	1 instal-lation	4	12
S5161	UA	Personal Emergency Response System	1 day	4	12
S5170	—	Frozen Home-Delivered Meal	1 meal	4	12
S5170	U1	Emergency Home Delivered Meals	1 meal	4	12
S5170	U2	Home-Delivered Meals	1 meal	4	12
T1005	—	Respite Care – Long-Term Facility-Based	15 min	1 or 7	21, 33, 99

262.200 Place of Service and Type of Service Codes 12-15-05

Place of Service	Paper Claims	Electronic Claims
Inpatient Hospital	1	21
Patient's Home	4	12
Day Care Facility	5	99
Nursing Home	7	33
Other Locations	0	99

Type of Service (paper only)
1 – ElderChoices