Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 TDD: 501-682-6789 & 1-877-708-8191 Internet Website: www.medicaid.state.ar.us

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

DATE: **February 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #59**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.000 – 212.312	Varies	212.000 – 212.312	2-1-06
212.320 – 212.322	12-15-05	212.320 – 212.322	2-1-06
213.100	6-1-05	213.100	2-1-06
213.210 – 213.220	12-15-05	213.210 – 213.220	2-1-06
213.310	10-13-03	213.310	2-1-06
213.321	12-15-05	213.321	2-1-06
213.400	7-1-05	213.400	2-1-06
213.500 – 213.600	12-15-05	213.500 – 213.600	2-1-06
213.700	12-15-05	213.700	2-1-06

Explanation of Updates

Throughout the manual, references that a physician must sign the ElderChoices plan of care have been removed. The following outline explains other specific changes affecting the ElderChoices program.

Section 212.000: New information has been added regarding the eligibility assessment process.

Section 212.100: The agency acronym was changed to **DHHS**.

Section 212.200: New information was added for clarity purposes.

Section 212.300: The information in this section has been updated with the new program requirements. It also details the new responsibilities of the DHHS RN as it relates to the ElderChoices plan of care form.

Section 212.305: This is a new section titled “Targeted Case Management Services” which explains how targeted case management is utilized in the ElderChoices program. This is not new information.

Sections 212.310 through 212.312: The sections relating to the plan of care types has been updated with new requirements.

Sections 212.320 through 212.322: These sections have been updated with the new program requirements for signing the ElderChoices plan of care, clarifying certain timeframes and deadlines and minor wording changes.

Sections 213.100, 213.210, 213.220, 213.310, and 213.321: A general updating of the information in these sections has occurred.

Section 213.400: A general updating of the information has occurred.

Section 213.500 and 213.510: A general updating of the information has occurred.

Section 213.600: Information in this section has been reworded for clarity purposes.

Section 213.700: Information in this section has been reworded for clarity purposes.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

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

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

_____

Roy Jeffus, Director

212.000 Eligibility Assessment 2-1-06

The client in-take and assessment process for the ElderChoices Program includes a determination of categorical eligibility, a level of care determination, the development of a plan of care and the client's notification of his or her choice between home and community-based services and institutional services. Costs effectiveness of the waiver program is determined annually in the aggregate and submitted to the Center for Medicare and Medicaid Services (CMS).

212.100 Financial Eligibility Determination 2-1-06

Financial eligibility for the Arkansas Medicaid Program must be verified as part of the client intake and assessment process for admission into the ElderChoices Program. Medicaid eligibility is determined by the DHHS county office located in the client's county of residence.

212.200 Level of Care Determination 2-1-06

The intermediate level of care determination is performed by medical staff assigned to the Department of Health and Human Services (DHHS) Utilization Review Team with the Office of Long Term Care. The intermediate level of care criteria provides 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 medical 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 DHHS-704.

212.300 Plan of Care 2-1-06

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. The election of community services by the waiver participant and

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

A copy of the plan of care signed by the DHHS RN and the waiver participant will be forwarded to the ElderChoices service provider(s) chosen by the client, family member, or DHHS RN, according to policy. 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.

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: All revisions to the plan of care must be authorized by the DHHS RN. A revised plan of care will be sent to each provider who is authorized to provide services under the plan of care. 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. Reimbursement for services not authorized on the ElderChoices plan of care are subject to recoupment.

212.305 Targeted Case Management Services (Non-Waiver Service) 2-1-06

Each ElderChoices plan of care will include Targeted Case Management, unless refused by the waiver participant. The Targeted Case Manager is responsible for monitoring the client's status on a regular basis for changes in their service need, reporting any client complaints to the DHHS RN or Program Administrator and reporting any changes to the DHHS RN. The waiver provider and the Targeted Case Manager are responsible for reporting any changes in services or changes in the client's status to the DHHS RN immediately upon learning of the change.

In addition to the monitoring performed by Targeted Case Managers, the DHHS RN's also routinely monitor caseloads as required through the Quality Managements Strategies established for the waiver program.

212.310 Provisional Plan of Care 2-1-06

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 and the Medicaid recipient ID number.

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

A provisional plan of care will be sent to providers 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

AND

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

212.311 Denied Eligibility Application 2-1-06

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 meet the nursing home admission criteria
2. Failure to meet financial eligibility 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 2-1-06

Prior to the expiration date of the provisional plan of care, the DHHS RN will mail the comprehensive plan of care 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 waiver eligibility date established according to 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.

212.320 Physician Authorization Of The ElderChoices Plan Of Care with Personal Care Services 2-1-06

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.

B. If a physician's signature is obtained on an ElderChoices plan of care and 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. If a physician's signature is not obtained on an ElderChoices plan of care, the personal care provider must secure a physician's order as provided in Medicaid Personal Care Program policy.

D. The ElderChoices plan of care is effective for one year, from the date of the DHHS RN's signature. This signature does not meet the requirements of the Medicaid Personal Care Program. If the ElderChoices plan of care does include an MD's signature, the authorization for personal care services, included on the ElderChoices plan of care, is 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 2-1-06

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 10 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 the agency's 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 2-1-06

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.

213.100 Adult Foster Care 2-1-06

Procedure Code	Description
S5140	Adult Foster Care

Adult foster care provides a family living environment for one or two clients who are functionally impaired and who, due to the severity of their functional impairments, are considered to be at imminent risk of death or serious bodily harm and, as a consequence, are not capable of fully independent living.

Adult foster care adds a dimension of family living to the provision of supportive services such as:

A. Bathing,

B. Dressing,

C. Grooming,

D. Care for occasional incontinence (bowel/bladder),

E. Assistance with eating and

F. Enhancement of skills and independence in daily living.

Services are provided in a home-like setting. The provider must include the client in the life of the family as much as possible. The provider must assist the client in becoming or remaining active in the community.

Services must be provided according to the client's written ElderChoices plan of care.

One (1) unit of service equals one (1) day. Adult foster care is limited to a maximum of thirty-one (31) units per month. Room and board costs are not included as a part of this service. Service payments are for the provision of daily living care to the client.

CLIENTS RECEIVING ADULT FOSTER CARE SERVICES ARE NOT ELIGIBLE TO RECEIVE ANY OTHER ELDERCHOICES SERVICE.

213.210 Homemaker Services 2-1-06

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 ElderChoices written plan of care.

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 2-1-06

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 ElderChoices plan of care.

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.

213.310 Hot Home-Delivered Meals 2-1-06

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible clients who are homebound.

Homebound is defined as a person with normal inability to leave home; that leaving home requires considerable and taxing effort by the individual and for whom absences from the home are infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the client must:

A. Be unable to prepare some or all of his or her own meals; and

B. Have no other individual to prepare his or her own meals; and

C. The provision of a home-delivered meal is the most cost-effective method of ensuring a nutritiously adequate meal and

D. Have the provision of the home-delivered meals included in his or her plan of care.

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

Hot Home-Delivered Meals may be provided to eligible clients daily. Additionally, clients may receive up to four (4) emergency meals per state fiscal year. A daily log sheet including the client's signature must be maintained by the provider to document receipt of the meal delivered. Section 214.000 contains information regarding additional documentation requirements.

Hot Home-Delivered Meals must be provided according to the client's written ElderChoices plan of care.

One (1) unit of service equals one (1) meal. Home-delivered meals are limited to a maximum of thirty-one (31) units per month and four (4) emergency meals per state fiscal year.

213.321 Participant Requirements for Frozen Home-Delivered Meals 2-1-06

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 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 ElderChoices plan of care.

213.400 Personal Emergency Response System 2-1-06

Procedure Code	Required Modifier	Description
S5161	UA	PERS Unit
S5160	—	PERS Installation

The Personal Emergency Response System (PERS) is an in-home, 24-hour electric support system with two-way verbal and electronic communication with an emergency control center. PERS enables an elderly, infirm or homebound individual to secure immediate help in the event of a physical, emotional or environmental emergency.

PERS is specifically designed for high-risk individuals whose needs have been carefully determined based on their level of medical vulnerability, functional impairment and social isolation. PERS is not intended to be a universal benefit. The DHHS RN must verify that the individual is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the client's written ElderChoices plan of care.

PERS providers must contact each client at least once per month to test the system's operation. The provider shall maintain a log of test calls that includes the date and time of the test, specific test results, corrective actions and outcomes.

A log of all client calls received must be maintained by the emergency response center. The log must reflect the date, time and nature of the call and the response initiated by the center. All calls must be documented in the client's record. See section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) day. PERS is limited to a maximum of thirty-one (31) units per month.

The installation of PERS will be allowed once per lifetime or period of eligibility. Claims submitted for the installation of PERS should use procedure code **S5160**. Procedure code **S5160** may be billed for ElderChoices clients who are accessing PERS services for their first time or for the current period of re-eligibility for ElderChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging and Adult Services for extension of the benefit.

View or print Division of Aging and Adult Services contact information.

213.500 Adult Day Care 2-1-06

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.

When provided according to the client's written ElderChoices plan of care, 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 2-1-06

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 Arkansas Department of Health and Human Services, Office of Long-Term Care 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) 2-1-06

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 provided according to the client's written ElderChoices 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.**

213.700 Respite Care 2-1-06

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 provided according to the client's written ElderChoices plan of care.