ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **January 1, 2013**

SUBJECT: **Provider Manual Update Transmittal SecV-8-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
500.000	—	500.000	—
DMS-0685-14	7/07	—	—
AAS-9565	4/07	—	—
—	—	AAS-9506	5/03

Explanation of Updates

Section 500.000 is updated to indicate that the Prior Authorization (PA) Request for Extension of Benefits-Prescription Drugs (Form DMS-0685-14) and the Assisted Living Waiver Plan of Care (Form AAS-9565) have been discontinued. It is also updated to add the Division of Aging and Adult Services Medicaid Waiver Program Quarterly Monitoring Report (Form AAS-9506).

Forms DMS-0685-14 and AAS-9565 have been discontinued.

Form AAS-9506 has been added to all provider manuals.

This transmittal and the enclosed form are for informational purposes only. **Please do not complete the enclosed form.**

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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

_____

Andrew Allison, PhD
Director

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J400	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adverse Effects Form	DMS-2704

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Explanation of Check Refund	HP-CR-002
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485

Form Name	Form Link
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Evaluation	DMS-650
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Assistance Dental Disposition	DMS-2635
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Procedure Code/NDC Detail Attachment Form	DMS-664
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A
Provider Enrollment Application and Contract Package	Application Packet
Quarterly Monitoring Form	AAS-9506
Referral for Audiology Services – School-Based Setting	DMS-7783
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634

Form Name	Form Link
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Evaluation	DMS-648
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9559
AAS-9506
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2635
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-2704
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit
Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit
Arkansas Department of Human Services, Children's Services

HP Enterprise Services Provider Assistance Center (PAC)

HP Enterprise Services Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

ICD-9-CM, CPT, and HCPCS Reference Book Ordering

Immunizations Registry Help Desk

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

QSource of Arkansas

Select Optical

Standard Register

Table of Desirable Weights

ValueOptions

U.S. Government Printing Office

Vendor Performance Report

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501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Living Choices Assisted Living**

DATE: **January 1, 2013**

SUBJECT: **Provider Manual Update Transmittal LCAL-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
200.000	10-13-03	200.000	1-1-13
200.100	10-13-03	200.100	1-1-13
—	—	200.105	1-1-13
200.110	10-13-03	200.110	1-1-13
200.111	10-08-10	200.111	1-1-13
200.120	10-13-03	200.120	1-1-13
200.130	10-13-03	200.130	1-1-13
200.200	10-13-03	200.200	1-1-13
200.210	10-13-03	200.210	1-1-13
200.230	10-13-03	200.230	1-1-13
202.100	10-13-03	202.100	1-1-13
202.200	10-13-03	202.200	1-1-13
210.000	07-15-12	210.000	1-1-13
211.000	10-13-03	211.000	1-1-13
211.100	07-15-12	211.100	1-1-13
—	—	211.150	1-1-13
211.200	06-01-09	211.200	1-1-13
212.000	06-01-08	212.000	1-1-13
212.100	10-13-03	212.100	1-1-13
212.200	10-13-03	212.200	1-1-13
212.310	10-13-03	212.310	1-1-13
212.320	10-13-03	212.320	1-1-13
212.500	10-13-03	212.500	1-1-13
212.600	10-13-03	212.600	1-1-13
213.000	10-13-03	213.000	1-1-13
214.000	06-01-08	214.000	1-1-13
—	—	215.000	1-1-13

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
216.200	10-13-03	216.200	1-1-13
216.210	10-13-03	216.210	1-1-13
216.220	10-13-03	216.220	1-1-13
216.240	10-13-03	216.240	1-1-13
216.260	10-13-03	216.260	1-1-13
250.100	10-13-03	250.100	1-1-13
250.200	10-13-03	250.200	1-1-13
262.100	06-01-08	262.100	1-1-13
262.310	06-01-08	262.310	1-1-13
262.420	10-13-03	262.420	1-1-13
262.430	10-13-03	262.430	1-1-13

Explanation of Updates

Sections 200.000, 200.100, 200.110, 200.120, 200.210, 200.230, 202.100, 202.200, 210.000, 211.000, 211.100, 211.200, 212.000, 212.100, 212.200, 212.310, 212.320, 212.500, 213.000, 214.000, 216.200, 216.210, 216.220, 216.240, 216.260, 250.100, 262.100, 262.310 and 262.420 are updated to reflect the most current rules and regulations for the Living Choices Assisted Living (LCAL) Waiver program based on a recent amendment to the LCAL Waiver.

Sections 200.105, 211.150 and 215.000 are added to reflect the most current rules and regulations for the Living Choices Assisted Living (LCAL) waiver program based on a recent amendment to the LCAL Waiver.

Sections 200.111, 200.130, 200.200, 212.600, 250.200 and 262.430 are set to “Reserved.”

Revisions to the LCAL provider manual comply with revisions to the waiver amendment approved by CMS effective January 1, 2013. The revisions were made to ensure agreement between the approved waiver document and the provider manual, provide further details regarding documentation requirements and primarily to provide policy regarding implementation of the universal assessment process for level of care determinations for this Home and Community-Based Services waiver program.

The paper version of this update transmittal includes revised pages that may be filed 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.

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Thank you for your participation in the Arkansas Medicaid Program.

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Andrew Allison, PhD
Director

TOC required

200.000 LIVING CHOICES ASSISTED LIVING GENERAL INFORMATION 1-1-13

The Arkansas Medicaid Living Choices Assisted Living Program is a home and community-based services waiver program, operating under the authority of Section 1915(c) of the Social Security Act.

In the text of this manual, the Living Choices Assisted Living Program is generally referred to informally as “Living Choices” or “the Living Choices Program,” with a few recurring exceptions.

200.100 Qualifying Criteria for Living Choices Assisted Living Providers 1-1-13

Living Choices providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program.

A. Assisted living facilities (ALF) are licensed and regulated by the Office of Long Term Care in the Division of Medical Services (DMS), which is the division of the Arkansas Department of Human Services (DHS) that administers the Arkansas Medicaid Program. Licensed Level II ALF are qualified to enroll with Medicaid as Living Choices Assisted Living Facilities—Direct Services Providers, if all other requirements for enrollment are met.

B. Home health agencies in Arkansas are licensed and regulated by the Arkansas Department of Health. Licensed Class A home health agencies may contract with Level II ALF to provide the bundled services covered in the Living Choices Program. In such an arrangement, federal regulations permit Medicaid to cover the services only if the home health agency, instead of the ALF, is the Living Choices provider.

Living Choices Assisted Living Waiver Services providers must meet the Provider Participation and enrollment requirements detailed in the Medicaid provider manual.

A licensed home health agency may qualify for Living Choices waiver services provider enrollment only by first contracting with a licensed Level II ALF to provide Living Choices bundled services to Living Choices beneficiaries who reside in the ALF.

200.105 Provider Assurances 1-1-13

A. Staffing

The Provider agrees that he or she will maintain adequate staffing levels to ensure timely and consistent delivery of services to all beneficiaries for whom they have accepted a Living Choices Assisted Living Waiver Plan of Care.

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.

3. Staff are required to attend orientation training prior to allowing the employee to deliver any Living Choices Assisted Living Waiver service(s). This orientation shall include, but not be limited to, a:

   a. Description of the purpose and philosophy of the Living Choices Assisted Living Waiver Program;

   b. Discussion and distribution of the provider agency's written code of ethics;

   c. Discussion of activities which shall and shall not be performed by the employee;

   d. Discussion, including instructions, regarding Living Choices Assisted Living Waiver record keeping requirements;

   e. Discussion of the importance of the Plan of Care;

   f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;

   g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality.

B. Quality Controls

The Provider agrees to continually monitor beneficiary satisfaction and quality of service delivery and to document his or her findings in the beneficiary's record every ninety days via the Quarterly Monitoring Form (AAS-9506). **View or print the AAS-9506 form.**

C. Code of Ethics

The Provider agrees to develop, distribute and enforce a written code of ethics with each employee providing services to a Living Choices Assisted Living Waiver beneficiary that shall include, but not be limited to, the following:

1. No consumption of the beneficiary's food or drink;
2. No use of the beneficiary's telephone for personal calls;
3. No discussion of one's personal problems, religious or political beliefs with the beneficiary;
4. No acceptance of gifts or tips from the beneficiary or their caregiver;
5. No friends or relatives of the employee or unauthorized individuals are to accompany the employee to the beneficiary's assisted living facility apartment unit;
6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery nor in the beneficiary's assisted living facility apartment unit;
7. No smoking in the beneficiary's assisted living facility apartment unit;
8. No solicitation of money or goods from the beneficiary;
9. No breach of the beneficiary's privacy or confidentiality of records.

200.110 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Facilities 1-1-13

Level II ALF located within the state of Arkansas and licensed by the Arkansas Division of Medical Services, Office of Long Term Care, are eligible to apply for Medicaid enrollment as Living Choices providers. Qualified Level II Assisted Living Facility providers contract with Medicaid as Living Choices Assisted Living Facility providers to provide and claim reimbursement for Living Choices bundled services instead of contracting with another entity (e.g., a licensed home health agency) that is enrolled with Medicaid to provide and receive payment for those services. Living Choices includes provisions for alternative methods of delivering services because assisted living facilities have different business and staffing

arrangements and the Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service. Additional details in this regard are provided in this manual.

200.111 Reserved 1-1-13

200.120 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Agencies 1-1-13

Within their licensing regulations, Level II ALF may contract with home health agencies and other entities and individuals to provide required and optional services for residents of the ALF. In the Living Choices Program, an ALF that chooses not to be the Medicaid-enrolled provider of Living Choices services may contract only with a licensed home health agency to furnish Living Choices bundled services. The Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service.

A Licensed Class A Home Health Agency is eligible to enroll in the Arkansas Medicaid Program as an Assisted Living Agency provider only if it has a contract with a Level II Assisted Living Facility to deliver all Living Choices bundled services furnished in that facility. A home health agency must have a separate Medicaid provider number for each ALF in which it is the Living Choices provider.

To enroll as a Living Choices Assisted Living Agency, the agency must comply with certain procedures and criteria. This section describes those criteria and procedures, as well as the actions DMS takes to facilitate enrollment.

A. The provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.

B. The provider must submit to the Medicaid program's Provider Enrollment Unit the following items, in addition to the other documentation required in this section.

1. A copy of its contract with the ALF (financial details may be omitted). The contract must describe in detail the agency's contractual obligations to provide Living Choices bundled services to the ALF's Living Choices beneficiaries.
2. Copies of contracts (financial details may be omitted) with any entities or individuals the agency has sub-contracted with to provide components of Living Choices bundled services.

200.130 Reserved 1-1-13

200.200 Provider Staffing Requirements for the Delivery of Bundled Services 1-1-13

The purpose of this section is to describe the types of employment and contractual arrangements that Medicaid regulations allow Living Choices facilities and agencies to make for the delivery of Living Choices bundled services. The legal basis for these requirements is the Social Security Act (the Act) at Section 1902(a)(27), Section 1902(a)(32) and Section 1902 (a)(23).

A. The referenced sections of the Act require the following.

1. There must be a provider agreement between a state Medicaid agency and each provider furnishing Title XIX (Medicaid) services.
2. State Medicaid agencies must make payment directly to the providers of services.
3. Individuals receiving Medicaid benefits must have free choice among available and qualified providers who are willing to furnish the service.

a. To be considered "qualified," an individual or entity must meet applicable provider qualifications set forth in the state's Title XIX State Plan or in an approved Medicaid waiver.

b. Qualifications must be considered reasonable by the Centers for Medicare and Medicaid Services (CMS).

c. CMS considers qualifications reasonable when they are directly related to the demands of the Medicaid service to be furnished.

B. The requirements—and alternative requirements, if any—set forth in the following sections resulted from CMS interpretations of those three stipulations of the Act. They represent the only legal methods currently available to fulfill staffing needs to deliver Living Choices services. Providers will be notified of alternatives as they are approved and implemented.

200.210 Staffing Requirements for Living Choices Assisted Living Facilities (ALF)—Direct Services Providers 1-1-13

A. Medicaid requires a Living Choices ALF—Direct Services Provider to furnish, with its own employees, not with contractors, Living Choices bundled services described in this manual.

1. An individual or entity may not enroll in Medicaid to provide a service or services, and then sub-contract actual service delivery to others. Such arrangements do not satisfy the stipulations of the Social Security Act stated above in Section 200.200.

2. Federal Medicaid regulations do permit an exception to the employee-only rule with respect to one component of Living Choices bundled services. The exception is described in part C of this section.

B. The employee-only rule satisfies the requirement that providers must be qualified to furnish the services they are enrolling to provide. CMS considers that a provider of bundled services may be deemed qualified if the provider furnishes the services through employees, which enables the provider to review and approve the qualifications of the individuals that actually deliver services. An ALF provider is responsible for verifying and maintaining pertinent documentation that individual employees are qualified to perform the functions for which they are hired.

1. An ALF employee is an individual who is employed by an ALF and who has on file with the ALF administration a current IRS form W-4.

2. Employees providing Living Choices services must be qualified to do so. The provider is responsible for ensuring that all Living Choices services are provided and documented, with documentation retained, in accordance with the provisions of this manual.

C. The employee-only rule may be waived, in one instance, with respect to nursing services in an ALF. Level II ALF licensing regulations require an ALF to engage nurses and Certified Nursing Aides to provide services that the regulations specify. Under those regulations, the nurses may be employees or contractors. If a nurse or aide is a contractor and the contract provides for him or her to furnish services required by the Living Choices Program, the arrangement does not violate the employee-only stipulation. However, the fact of this particular arrangement's exemption from that requirement does not exempt the facility from the employee-only requirement with respect to any other staff member providing Living Choices services.

200.230 Staffing Requirements for Living Choices Assisted Living Agencies 1-1-13

Living Choices Assisted Living Agencies have available two methods by which they may engage staff to furnish Living Choices bundled services.

A. The traditional method is using only employees, not contractors, to furnish the services. Its home health license confirms that the agency is qualified to provide home health services. The provider meets the state's qualification requirement by virtue of its licensure, and its enrollment as a Living Choices services provider, which is based on the agency's contract with a Level II ALF. These qualification criteria easily pass the CMS test of reasonableness.

B. Another method is to use both employees and contractors to provide services. Federal regulations allow home health agencies to contract for provision of component parts (but not all component parts) of the full service (home health) they are licensed to provide. However, the enrolled provider is held responsible for the provision of the service "in toto," and each component of the service (whether furnished directly by the provider or by someone else under contract to the provider) must meet the applicable standards set forth by the Medicaid agency for the provision of that component of care.

202.100 Records that Living Choices Assisted Living Facilities and Agencies Must Keep 1-1-13

A. Living Choices Assisted Living facility and agency providers must maintain required personal care aide training program documentation as specified in this manual.

B. A provider must also maintain the following items in each Living Choices beneficiary's file.

1. The beneficiary's attending or primary care physician's name, office address, telephone number and after-hours contact information.
2. A copy of the beneficiary's current plan of care (form AAS-9503).
3. Written instructions to the facility's attendant care staff.
4. Documentation of limited nursing services performed by the provider's nursing staff in accordance with the beneficiary's plan of care. Records must include:
   a. Nursing service or services performed,
   b. The date and time of day that nursing services are performed,
   c. Progress or other notes regarding the resident's health status and
   d. The signature or initials and the title of the person performing the services.
5. Documentation of periodic nursing evaluations performed by the ALF nursing staff in accordance with the beneficiary's plan of care.
6. Records of attendant care services as described in this manual.
7. Service providers are required to follow all guidelines in the Medicaid Provider Manual related to monitoring, including types of monitoring, timeframes, reporting and documentation requirements. Providers are required to report any change in the beneficiary's condition to the DAAS RN, who is the only authorized individual who may adjust a beneficiary's plan of care. Providers agree to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community-Based Services Waiver Provider Manual; to comply with all policies, procedures and guidelines established by DAAS; to notify the DAAS RN immediately of any change in the beneficiary's physical, mental or environmental needs the provider observes or is made aware of that may affect the beneficiary's eligibility or necessitate a change in the beneficiary's plan of care; to continually monitor beneficiary satisfaction and quality of service delivery and to record their findings every 90 days by completing the Quarterly Monitoring Form (AAS-9506); and to notify the DAAS RN in writing within one week of services being terminated, documenting the termination effective date and the reason for termination.

202.200 Reserved 1-1-13

210.000 PROGRAM COVERAGE 1-1-13

Living Choices Assisted Living is a home and community-based services waiver program that is administered jointly by the Division of Medical Services (DMS, the state Medicaid agency) and the Division of Aging and Adult Services (DAAS), under the waiver authority of Section 1915(c) of the Social Security Act. Home and community-based services waiver programs cover services designed to allow specific populations of individuals to live in their own homes or in certain types of congregate settings. The Living Choices Assisted Living waiver program serves persons aged 65 and older and persons aged 21 through 64 who are determined to be individuals with physical disabilities by the Social Security Administration or the Arkansas DHS Medical Review Team (MRT), and who are eligible for nursing home admission at the intermediate level of care.

The rules and regulations for licensure of Level II Assisted Living Facilities (ALF) are administered by the Office of Long Term Care within DMS. As agencies of the Arkansas Department of Human Services (DHS), DAAS, DMS and the Division of County Operations (DCO) administer the policies and procedures and the rules and regulations governing provider and beneficiary participation in the Living Choices Program.

Individuals found eligible for the Living Choices Program may participate in the program when residing in a licensed Level II ALF that is enrolled as a Living Choices waiver provider in the Arkansas Medicaid Program.

211.000 Scope of the Program 1-1-13

The *Level II Assisted Living Facilities Rules and Regulations* manual defines assisted living as: "Housing, meals, laundry, social activities, transportation (assistance with and arranging for transportation), one or more personal services, direct care services, health care services, 24-hour supervision and care, and limited nursing services." Medicaid, by federal law, may not cover beneficiaries' room and board except in nursing and intermediate care facilities. Medicaid covers some services only under certain conditions. This home and community-based services waiver program permits Medicaid coverage of assisted living services as described in this manual.

Individuals participating in the Living Choices Program reside in apartment-style living units in licensed Level II ALF and receive individualized personal, health and social services that enable optimal maintenance of their individuality, privacy, dignity and independence. The assisted living environment actively encourages and supports these values through effective methods of service delivery and facility or program operation. The environment promotes residents' self-direction and personal decision-making while protecting their health and safety.

Assisted living includes 24-hour on-site response staff to assist with residents' known physical dependency needs or other conditions, as well as to manage unanticipated situations and emergencies. Assisted living provider staff perform their duties and conduct themselves in a manner that fosters and promotes residents' dignity and independence. Supervision, safety and security are required components of the assisted living environment. Living Choices includes therapeutic social and recreational activities suitable to residents' abilities, interests and needs.

Services are provided on a regular basis in accordance with individualized plans of care that are signed by a DAAS registered nurse. Assisted living beneficiaries reside in their own living units, which are separate and distinct from all others. Laundry and meal preparation and service are in a congregate setting for beneficiaries who choose not to perform those activities themselves.

211.100 Eligibility for the Living Choices Assisted Living Program 1-1-13

A. To qualify for the Living Choices Program, an individual must meet the targeted population as described in this manual and must be found to require a nursing facility intermediate

level of care. Individuals meeting the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the Living Choices Assisted Living Program.

The beneficiary intake and assessment process for the Living Choices Program includes a level of care determination, the development of a plan of care and the beneficiary's notification of his or her choice between home- and community-based services and institutional services.

B. Candidates for participation in the program (or their representatives) must make application for services at the DHS office in the county in which the Level II ALF is located. Medicaid eligibility is determined by the DHS County Office and is based on non-medical and medical criteria. Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a functional disability.

C. To be determined an individual with a functional disability, an individual must meet at least one of the following three criteria, as determined by a licensed medical professional.

1. The individual is unable to perform either of the following:
   a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon, another person; or
   b. At least 2 of the 3 ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or
2. Medical assessment results in a score of three or more on Cognitive Performance Scale; or
3. Medical assessment results in a Changes in Health, End-Stage Disease and Symptoms and Signs (CHESS) score of three or more.

D. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition that is temporary and expected to last no more than 21 days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than 21 days.

E. Individuals diagnosed with a serious mental illness or mental retardation are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.

F. Eligibility for the Living Choices waiver program is determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the plan of care is signed by the DAAS RN and beneficiary. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)

G. The Living Choices waiver provides for the entrance of all eligible persons on a first come, first-served basis, once individuals meet all medical and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated beneficiaries is projected to be reached considering the number of active cases and the number of pending applications, a waiting list will be implemented for this program and the following process will apply:

1. Each Living Choices application will be accepted and medical and financial eligibility will be determined.

2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled, and that the applicant is number X in line for an available slot.

3. Entry to the waiver will then be prioritized based on the following criteria:

   a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error;

   b. Waiver application determination date for persons being discharged from a nursing facility after a 90-day stay; waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer;

   c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS);

   d. Waiver application determination date for all other persons.

211.150 Level of Care Determination 1-1-13

A prospective Living Choices beneficiary must require a nursing facility intermediate level of care.

The intermediate level of care determination is made by medical staff with the Department of Human Services (DHS), Office of Long Term Care. The determination is based on the assessment performed by the DAAS RN, using standard criteria for functional disability in evaluating an individual's need for nursing home placement in the absence of community alternatives. The level of care determination, in accordance with 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 Living Choices services.

The DAAS RN performs an assessment periodically (at least annually), and the Office of Long Term Care re-determines level of care annually. The results of the level of care determination and the re-evaluation are documented on form DHS-704, Decision for Nursing Home Placement.

NOTE: While federal guidelines require level of care reassessment at least annually, DAAS may reassess a beneficiary's level of care and/or need any time it is deemed appropriate by the DAAS RN to ensure that a beneficiary is appropriately placed in the Living Choices Assisted Living Program and is receiving services suitable to his or her needs.

211.200 Plan of Care 1-1-13

A. Each beneficiary in the Living Choices Assisted Living Program must have an individualized Living Choices Plan of Care (AAS-9503). The authority to develop a Living Choices plan of care is given to the Medicaid State agency's designee, the Division of Aging and Adult Services Registered Nurse (DAAS RN). The Living Choices plan of care developed by the DAAS RN includes, but is not limited to:

1. Beneficiary identification and contact information to include full name and address, phone number, date of birth, Medicaid number and the effective date of Living Choices Assisted Living waiver eligibility;

2. Primary and secondary diagnosis;

3. Tier Level;

4. Contact person;

5. Physician's name and address;

6. The amount, frequency and duration of required Living Choices services and the name of the service provider chosen by the beneficiary or representative to provide the services;

7. Other services outside the Living Choices services, regardless of payment source identified and/or ordered to meet the beneficiary's needs. Living Choices providers are not required to provide these services, but they may not impede their delivery.

8. The election of community services by the waiver beneficiary; and

9. The name and title of the DAAS RN responsible for the development of the plan of care.

10. Each beneficiary, or his or her representative, has the right to choose the provider of each non-waiver service. Non-waiver services are the services listed on the plan of care that are not included in the bundled services of the Living Choices Program (e.g., medical equipment rental). The plan of care names the provider that the beneficiary (or the beneficiary's representative) has chosen to provide each service.

B. A copy of the plan of care signed by the DAAS RN and the waiver beneficiary will be forwarded to the beneficiary and the Living Choices service provider(s) chosen by the beneficiary or representative, if waiver eligibility is approved by the DHS County Office. Each provider is responsible for developing an implementation plan in accordance with the beneficiary plan of care. The original plan of care will be maintained by the DAAS RN.

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

1. Individualized to the beneficiary's unique circumstances;

2. Provided in the least restrictive environment possible;

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

4. Monitored and adjusted as needed, based on changes to the waiver plan of care, as reported by the DAAS RN;

5. Provided within a system that safeguards the beneficiary's rights; and

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

NOTE: Each service included on the Living Choices plan of care must be justified by the DAAS RN. This justification is based on medical necessity, the beneficiary's physical, mental and functional status, other support services available to the beneficiary, and other factors deemed appropriate by the DAAS RN.

Living Choices services must be provided according to the beneficiary plan of care. Providers may bill only for services in the amount and frequency that is authorized in the plan of care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

C. The assisted living provider employs or contracts with a Registered Nurse (the "assisted living provider RN") who implements and coordinates plans of care, supervises nursing and direct care staff and monitors beneficiaries' status. At least once every three months, the assisted living provider RN must evaluate each Living Choices beneficiary.

D. The DAAS RN must reevaluate a beneficiary's medical condition within fourteen days of being notified of any significant change in the beneficiary's condition. The assisted living RN is responsible for immediately notifying the DAAS RN regarding beneficiaries whose status or condition has changed and who need reevaluation and reassessment.

REVISIONS TO A BENEFICIARY PLAN OF CARE MAY ONLY BE MADE BY THE DAAS RN.

NOTE: All revisions to the plan of care must be authorized by the DAAS 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 a Living Choices plan of care, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the Living Choices plan of care are subject to recoupment.

E. An individual may be served in a Level II Assisted Living Facility under a provisional plan of care developed by the beneficiary and the DAAS RN and signed by the beneficiary or the beneficiary's representative and the DAAS RN, if the beneficiary and the provider accept the risk of possible ineligibility.

1. A provisional plan of care may be effective for no more than 60 days.

2. If approved by the Division of County Operations, eligibility for the program will be determined as the latter of the date of application for the program, the date of admission to the assisted living facility, or the date the provisional plan of care is signed by the DAAS RN and the beneficiary, and a plan of care will be sent to the provider.

NOTE: No provisional plans of care will be developed if the waiting list process is in effect.

212.000 Living Choices Assisted Living Services 1-1-13

Once a Living Choices eligibility application has been approved, waiver services must be provided in order for eligibility to continue. Medicaid covers Living Choices services on a daily, all-inclusive basis, rather than on an itemized per-service basis. With the exception explained in the NOTE below, a day is a covered date of service when a beneficiary receives any of the services described as a covered ALF service in this manual, when the service is received between midnight on a given day and midnight of the following day. A day is not a covered date of service when a beneficiary does not receive any Living Choices services between midnight of that day and midnight of the following day.

NOTE: The Arkansas Medicaid Program considers an individual an inpatient of a facility beginning with the date of admission. Therefore, payment to the inpatient facility begins on the date of admission. Payment to the inpatient facility does not include the date of discharge.

Living Choices waiver services are not allowed on the same day as an individual is admitted to an inpatient facility, regardless of the time of day. If the inpatient facility (hospital, rehab hospital, nursing facility or ICF/MR) is reimbursed by Medicaid on any given day, the ALF waiver provider is not allowed reimbursement for Living Choices service on the same day.

For example: If a waiver beneficiary is taken and admitted to the hospital on 6/10/12 at 10 a.m. and discharged on 6/13/12 at 10:00 p.m., the hospital will be reimbursed by Medicaid for that date of admission, 6/10/12, but will not be reimbursed for the date of discharge, 6/13/12. In this scenario, the individual left the ALF II facility, was admitted to the hospital, and was returned to the ALF II facility after 3 days of hospitalization.

Date of Admission – 6/10/12 at 10:00 a.m. – Reimbursement to the hospital

6/11/12 – Reimbursement to the hospital

6/12/12 – Reimbursement to the hospital

Date of Discharge – 6/13/12 at 10:00 p.m. – Reimbursement to the ALF facility

The time of admission and the time of discharge are not relevant. Payment is made to the two facilities based on the dates of service.

A. Basic Living Choices Assisted Living direct care services are:

1. Attendant care services,
2. Therapeutic social and recreational activities,
3. Periodic nursing evaluations,
4. Limited nursing services,
5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing,
6. Medication oversight to the extent permitted under Arkansas law and
7. Assistance obtaining non-medical transportation specified in the plan of care.

B. Living Choices participants are eligible for pharmacist consultant services. Level II ALFs are required by their licensing regulations to engage a Consultant Pharmacist in Charge.

NOTE: The removal of Pharmacy Consultant Services as a waiver service does not change the provision of the service, as required under the Level II ALF licensing regulations.

Living Choices waiver beneficiaries are eligible for the same prescription drug benefits of regular Medicaid, plus three (3) additional prescriptions for a total of nine (9) per month. No prior authorization is required for the three additional prescriptions. Living Choices waiver beneficiaries who are dual eligible (receiving both Medicare and Medicaid) must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

212.100 Attendant Care Services 1-1-13

A. Attendant care is a direct care service to help a medically stable individual who has physical dependency needs in accomplishing activities and tasks of daily living that the individual is usually or always unable to perform independently.

1. Living Choices beneficiaries are furnished attendant care on an individualized basis for assistance with eating and nutrition, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements.
2. Attendant care may include assistance with incidental housekeeping and shopping for personal care items or food.
3. With regard to assistance with medication (for residents who elect to self-administer their medications) attendant care services include only the very limited functions detailed in Section 702.1.1.5F of the Level II Assisted Living Facilities Rules and Regulations.

B. Activities that constitute assisting a person with physical dependency needs vary.

1. One might perform the entire task (e.g., buttoning his shirt for him), or assist the person in performing the task (e.g., helping him line up button and buttonhole).
2. Assistance might consist of simply providing safety support while the person performs the task (e.g., providing support so he can let go of his cane while he buttons his shirt).

3. Attendant care services may include supervision, visual or auditory cueing, or only observation of a person performing a task or activity to ensure completion of the activity or the safety of the individual.

C. The assisted living provider RN's attendant care instructions must be based, at a minimum, on the waiver plan of care.

D. The minimum qualifications of an individual providing attendant care in the Living Choices Program are those of a certified personal care aide. See personal care aide training and certification requirements in this manual.

E. Individuals participating in the Living Choices Program are not eligible to access personal care services or extended personal care services through the Arkansas Medicaid Personal Care Program.

212.200 Periodic Nursing Evaluations 1-1-13

The assisted living provider RN must evaluate each Living Choices Program beneficiary at least every three months, more often if necessary. The assisted living provider RN must alert the DAAS RN to any indication that a beneficiary's direct care services needs are changing or have changed, so that the DAAS RN can reassess the individual.

Each Living Choices beneficiary will be evaluated at least annually by a DAAS RN. The DAAS RN evaluates the resident to determine whether a nursing home intermediate level of care is still appropriate and whether the plan of care should continue unchanged or be revised. Re-evaluations and subsequent plan of care revisions must be made within fourteen days of any significant change in the beneficiary's status.

212.310 Registered Nurse (RN) Limited Nursing Services 1-1-13

RN limited nursing services include:

A. Assessing each Living Choices beneficiary's health care needs,

B. Implementing and coordinating the delivery of services ordered on the assisted living plan of care,

C. Monitoring and assessing the beneficiary's health status on a periodic basis,

D. Administering medication and delivering limited medical services as provided by Arkansas law and applicable regulations and

E. Making referrals to physicians or community agencies as appropriate.

212.320 Licensed Practical Nurse (LPN) Limited Nursing Services 1-1-13

LPN limited nursing services are provided under the supervision of an RN and include:

A. Monitoring each waiver beneficiary's health status,

B. Administering medication and delivering limited medical services as provided by Arkansas law or applicable regulation and

C. Notifying the RN if there are significant changes in a beneficiary's health status.

212.500 Non-Medical Transportation 1-1-13

Living Choices providers must assist beneficiaries with obtaining and accessing non-medical transportation as required on the plan of care.

212.600 Reserved 1-1-13

213.000 Additional Services 1-1-13

Other individuals or agencies may also furnish care directly or under arrangement with the Living Choices provider, but the care provided by other entities may only supplement that provided by the Living Choices provider and may not supplant it.

Beneficiaries in the Living Choices Assisted Living Program may receive Title XIX (Medicaid) State Plan services that are provided by enrolled Medicaid providers (e.g., medical equipment rental, prescription drugs) if all eligibility requirements for the specific Medicaid covered service have been met. Beneficiaries may not receive services under the Arkansas Medicaid Personal Care Program.

214.000 Benefit Limits 1-1-13

A. Living Choices Assisted Living bundled services are limited to one unit per day.

B. Living Choices Assisted Living Program beneficiaries may have as many as nine prescription drugs per month covered by Medicaid. Dual eligibles, receiving both Medicare and Medicaid, receive prescription drug coverage through Part D Medicare. Medicare has no restrictions on the number of prescription drugs that can be received during a month. Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

215.000 Living Choices Forms 1-1-13

Living Choices 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, Beneficiary 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 DHS RN.

Instructions for completion and retention are included with each form. If there are questions regarding any waiver form, providers may contact the DHS RN in your area.

216.200 Personal Care Aide Training Subject Areas 1-1-13

A qualified personal care aide training and certification program must include instruction in each of the following subject areas.

A. Correct conduct toward beneficiaries, including respect for the beneficiary, the beneficiary's privacy and the beneficiary's property.

B. Understanding and following spoken and written instructions.

C. Communications skills, especially the skills needed to:

1. Interact with beneficiaries,
2. Report relevant and required information to supervisors and
3. Report events accurately to public safety personnel and to emergency and medical personnel.

D. Record-keeping, including:

1. The role and importance of record keeping and documentation,
2. Service documentation requirements and procedures,
3. Reporting and documenting non-medical observations of beneficiary status and
4. Reporting and documenting, when pertinent, the beneficiary's observations regarding his or her own status.

E. Recognizing and reporting to the supervising RN changes in the beneficiary's condition or status that require the aide to perform tasks differently than instructed.

F. State law regarding delegation of nursing tasks to unlicensed personnel.

G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.

H. Safe transfer techniques and ambulation.

I. Normal range of motion and positioning.

J. Recognizing emergencies and knowledge of emergency procedures.

K. Basic household safety and fire prevention.

L. Maintaining a clean, safe and healthy environment.

M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the beneficiary with:

1. Bed bath,
2. Sponge, tub or shower bath,
3. Shampoo (sink, tub or bed),
4. Nail and skin care,
5. Oral hygiene,
6. Toileting and elimination,
7. Shaving,
8. Assistance with eating,
9. Assistance with dressing,
10. Efficient, safe and sanitary meal preparation,
11. Dishwashing,
12. Basic housekeeping procedures and
13. Laundry skills.

216.210 Personal Care Aide Training Requirements 1-1-13

Classroom and supervised practical training must total at least 40 hours.

A. Minimum classroom training time is 24 hours.

B. Minimum time for supervised practical training is 16 hours.

1. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge by performing tasks on an individual while the trainee is under supervision.

2. Trainees must complete at least 16 hours of classroom training before beginning any supervised practical training.

3. Supervised practical training may occur at locations other than the site of the classroom training.

   a. Trainees must complete at least 24 hours of classroom training before undertaking any supervised practical training that involves Living Choices beneficiaries or Medicaid-eligible individuals who receive Arkansas Medicaid Personal Care services.

   b. The training program must have the written consent of Living Choices beneficiaries or other Medicaid-eligible individuals (or their representatives) if aide trainees furnish any Attendant Care or personal care to those individuals as part of the supervised practical training.

      i. A copy of each such consent must be maintained in the trainee's file.

      ii. The beneficiary's (or the personal care beneficiary's) daily service documentation must include the names of the supervising RN and the personal care aide trainees.

4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse with current Arkansas licensure.

   a. The qualified registered nurse must possess a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of in-home health care.

   b. Other individuals may provide instruction under the supervision of the qualified registered nurse.

   c. Supervised practical training with a consenting Living Choices beneficiary or personal care beneficiary as the subject must be personally supervised by:

      i. A qualified registered nurse or

      ii. A licensed practical nurse under the general supervision of the qualified registered nurse.

216.220 Personal Care Aide Training Documentation 1-1-13

A. Medicaid requires the following documentation of training:

1. The number of hours each of classroom instruction and supervised practical training.

2. Names and qualifications of instructors and current copies of licenses of supervising registered nurses.

3. Street addresses and physical locations of training sites, including facility names when applicable.

4. If the training includes any supervised practical training in the homes of personal care beneficiaries or in the residences of Living Choices beneficiaries, the forms documenting the beneficiary's or resident's consent to the training in their home.

5. The course outline.

6. Lesson plans.

7. A brief description of the instructor's methods of supervising trainees during practical training.
8. The training program's methods and standards for determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide.
9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course.
10. The training program's minimum standard for successful completion of the course.
11. Evidence and documentation of successful completions (certificates supported by internal records).

B. The Living Choices provider is responsible for the upkeep of all required training program documentation, regardless of whether the training is in-house or by contract.

216.240 Personal Care Aide Selection 1-1-13

A. A personal care aide must be at least 18 years of age at the time of personal care aide certification.

B. A Living Choices beneficiary may receive attendant care services only from a certified personal care aide who is not a legally responsible family member or legally responsible caregiver. The Medicaid agency defines, "a legally responsible family member or legally responsible caregiver" as:

1. A spouse.
2. A legal guardian of the person
3. An attorney-in-fact authorized to direct care for the beneficiary.

C. Living Choices attendants must be selected on the basis of such factors as:

1. A sympathetic attitude toward the care of the sick,
2. An ability to read, write and carry out directions and
3. Maturity and ability to deal effectively with the demands of the job.

D. The Living Choices provider is responsible for ensuring that attendants in its employ:

1. Are certified as personal care aides,
2. Participate in all required in-service training and
3. Maintain at least "satisfactory" competency evaluations from their supervisors in all attendant care tasks they perform.

216.260 In-Service Training 1-1-13

Medicaid requires personal care aides to participate in least twelve (12) hours of in-service training every twelve (12) months after achieving Personal Care Aide certification.

A. Each in-service training session must be at least 1 hour in length.

1. When appropriate, in-service training may occur at an assisted living facility when the aide is furnishing services.
2. In-service training while serving a Living Choices beneficiary may occur only if the beneficiary or the beneficiary's representative has given prior written consent for training activities to occur concurrently with the beneficiary's care.

B. The Living Choices provider and the personal care aide must maintain documentation that they are meeting the in-service training requirement.

C. Providers are required to attend at least one in-service per calendar year. Required in-services are co-sponsored by DMS and DAAS.

250.100 Reimbursement of Living Choices Assisted Living Facilities and Agencies 1-1-13

Medicaid reimbursement to Living Choices facility and agency providers is a daily rate that corresponds to the tier of need in which the DAAS RN places a beneficiary. The determination of the tier of need is based on the comprehensive assessment. There are four tiers of need. The daily rate pays for all direct care services in the beneficiary's plan of care. Reimbursement is for services only; room and board are to be paid by the beneficiary or his or her legal representative.

A day is a covered date of service when a Living Choices beneficiary receives any of the services described in Sections 212.100 through 212.500 between midnight of that day and midnight of the following day.

250.200 Reserved 1-1-13

262.100 Living Choices Assisted Living Procedure Codes 1-1-13

Procedure Code	Modifier	Description
T2031	U1	Living Choices Assisted Living Tier 1
T2031	U2	Living Choices Assisted Living Tier 2
T2031	U3	Living Choices Assisted Living Tier 3
T2031	U4	Living Choices Assisted Living Tier 4

262.310 Completion of CMS-1500 Claim Form 1-1-13

Field Number and Name		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the individual's Medicaid identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).

Field Number and Name	Instructions for Completion
CITY	Name of the city in which the beneficiary resides.
STATE	Two-letter postal code for the state in which the beneficiary resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the beneficiary's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the beneficiary's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. PATIENT STATUS	Not required.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If beneficiary has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. OTHER INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured individual's employer and/or school.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Not required.
b. AUTO ACCIDENT?	Not required.
PLACE (State)	Not required.
c. OTHER ACCIDENT?	Not required.
10d. RESERVED FOR LOCAL USE	Not used.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.

Field Number and Name	Instructions for Completion
SEX	Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT:	Not required.
ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not required.
19. RESERVED FOR LOCAL USE	Not used.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	ICD-9-CM diagnosis code for the beneficiary's primary medical condition. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) diagnosis coding current as of the date of service.
22. MEDICAID RESUBMISSION CODE	Reserved for future use.

Field Number and Name			Instructions for Completion
	ORIGINAL REF. NO.		Reserved for future use.
23.	PRIOR AUTHORIZATION NUMBER		The prior authorization or benefit extension control number if applicable.
24A.		DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
	B.	PLACE OF SERVICE	Two-digit national standard place of service code.
	C.	EMG	Not required.
	D.	PROCEDURES, SERVICES, OR SUPPLIES	
		CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
		MODIFIER	Modifier(s) if applicable.
	E.	DIAGNOSIS POINTER	Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field.
	F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the provider’s usual charge to any beneficiary.
	G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
	H.	EPSDT/Family Plan	Not required.
	I.	ID QUAL	Not required.
	J.	RENDERING PROVIDER ID #	Not required.
		NPI	Not required.
25.	FEDERAL TAX I.D. NUMBER		Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT’S ACCOUNT N O.		Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as “MRN.”

Field Number and Name	Instructions for Completion
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. ***Do not** include in this total the automatically deducted Medicaid co-payments.
30. BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	Enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.420 Dates of Service 1-1-13

Dates of service may be itemized or expressed in a date of service range; i.e., "From Date" and "Through Date." A date of service range may include only covered days.

262.430 Reserved 1-1-13

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
DAAS MEDICAID WAIVER PROGRAM

QUARTERLY MONITORING FORM

Each quarter the waiver provider must report their monitoring of waiver clients by completing the AAS-9506. During the client review process, a quarterly monitoring report must be completed on all ElderChoices/Alternatives/Assisted Living clients, if an AAS-9511 or MIS Client Change of Status Form has not been submitted during the previous three (3) month period. For any waiver client that an AAS-9511 or MIS Client Change of Status Form has been sent to the DHS RN/Rehab Counselor during the reporting period, the provider is not required to complete a quarterly monitoring report. If, during the review process, a change in status is discovered that was not reported at the time the change occurred, an AAS-9511 or MIS Client Change of Status Form should be sent to the DHS RN/Rehab Counselor. The AAS-9506 forms completed that show no change has occurred during the quarter should be filed in the client's medical case record according to Medicaid policy regarding retention of records. The quarterly reporting schedule is shown below.

TO: **DIVISION OF AGING AND ADULT SERVICES**

FROM: **Waiver Provider** _____

CLIENT _____ **SS# or Medicaid #** _____ **County** _____

First Quarter	Complete report forms first week in April	Date _____
Second Quarter	Complete report forms first week in July	Date _____
Third Quarter	Complete report forms first week in October	Date _____
Fourth Quarter	Complete report forms first week in January	Date _____

Please Complete the Following	circle one		Date
1. Has the client entered the nursing home during this quarter?	yes	no	_____
2. Has the client entered the hospital this quarter?	yes	no	_____
3. Have services resumed?	yes	no	_____
4. Has the client expired during this quarter?	yes	no	_____
5. Has the client changed address during this quarter?	yes	no	_____
If yes, please indicate the new address below.			
6. **Services discontinued**.	yes	no	_____

Reason _____

_____

7. Other Changes _____

8. Comments _____

_____

NOTE: PERS providers are excluded from the quarterly monitoring requirement. All other ElderChoices and/or Alternatives providers must complete the quarterly monitoring form.

IF THERE HAVE BEEN ANY CHANGES IN SERVICES OR IF SERVICES HAVE BEEN DISCONTINUED, PLEASE NOTIFY THE DHS RN/REHABILITATION COUNSELOR IMMEDIATELY VIA THE DAAS-9511, CHANGE OF STATUS FORM.

AAS-9506 (R.05/03)