All ARChoices Home and Community-Based Services (HCBS) Waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

ARChoices HCBS Waiver providers must be licensed and/or certified by the Division of Provider Services and Quality Assurance (DPSQA) Aging and Adult Services (DAAS) as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria for the service(s) they wish to enroll to provide.

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

All providers must maintain their provider files at the Provider Enrollment Unit by submitting current certification, licensure, all DPSQADAAS-issued certification renewals and any other renewals affecting their status as a Medicaid-eligible provider, etc.

Copies of licensure/certifications and renewals required by DPSQADAAS must be maintained by DPSQADAAS to avoid loss of provider certification. These copies must be submitted to DPSQADAAS Provider Certification. View or print the Division of Provider Services and Quality Assurance Aging and Adult Services Provider Certification contact information. Payment cannot be authorized for services provided beyond the certification period.

The ARChoices Program began January 1, 2016. The program is the combination of the ElderChoices and Alternatives for Adults with Physical Disabilities (AAPD) waivers. Beginning January 1, 2016, beneficiaries enrolled in the ElderChoices and AAPD waiver programs became beneficiaries of the ARChoices program. The following transition plan explains the process of how services will be executed and billed until the beneficiary receives a new Person-Centered Service Plan (PCSP).

Individuals currently in the ElderChoices waiver will continue receiving current services at the same level and from the same provider until the next scheduled reassessment with the following exceptions:

- Homemaker and Adult Companion - Individuals will continue receiving Homemaker and Adult Companion hours as shown on the plan of care, except the services will be billed by the provider as Attendant Care in ARChoices.
- Respite - Individuals will continue receiving Respite and the definition will remain the same, but providers will bill for ARChoices Respite.
- Chore - This service is being eliminated due to underutilization. The number of participants who utilized the Chore service in State Fiscal Year 2015 was zero. Chore providers will be notified of the elimination of Chore services.
At reassessment, the DAAS RN will complete a new ARChoices PCSP and indicate any changes in services. A new service will be available to ElderChoices beneficiaries, Environmental Accessibility Adaptations/Adaptive Equipment.

Individuals currently in the Alternatives for Adults with Physical Disabilities (AAPD) waiver will be converted to ARChoices in Homecare when changes are implemented with no lapse in coverage or services. Beneficiaries will be notified of the changes at least 30 days in advance of implementation. During the reassessment and PCSP development, the AAPD individual will choose a TCM provider, and the DAAS RN will make a referral to the TCM provider of choice. The TCM provider will then make arrangements to visit the participant. The IndependentChoices counseling provider will also begin a series of visits to ensure proper support for self-direction under 1915(j). At reassessment, the DAAS RN and the beneficiary will complete a new ARChoices PCSP and indicate any changes in services.

Participants receiving AAPD Attendant Care under the Participant-Directed (PD) model will continue to receive the same services from the same provider until reassessment, at which time the service may continue under ARChoices Attendant Services as a PD service. The PD model for ARChoices will be different from the PD model for AAPD as ARChoices will use the 1915(j) authority approved by CMS for the operation of the IndependentChoices program and the self-directed supports offered to program participants. The same Attendant Care provider will continue to provide services under the IndependentChoices program. At the next reassessment, the IndependentChoices Counseling Support and Financial Management Services (FMS) provider will work with the beneficiary and Attendant Caregiver to provide training, support, and assistance in understanding the changes in the PD model and in completing the paperwork necessary to transition to the new model.

Provider training will be offered to current ElderChoices and AAPD providers regarding these changes as well as training on the new billing requirements. Training will be provided to HCBS waiver staff regarding the transition from the existing waivers to one waiver.

Beginning with the first reassessment, the individual will have an expanded array of services from which to choose. Individuals will also be able to keep the same services and providers when turning age 65.

Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.

201.100 Providers of ARChoices HCBS Waiver Services in Bordering and Non-Bordering States  1-1-16

An ARChoices provider must be physically located in the State of Arkansas or physically located in a bordering state and serving a trade-area city. The trade-area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.

All providers must be licensed and/or certified by their states’ appropriate licensing/certifying authorities. Copies of all appropriate licenses and certifications must be submitted to DPSQADAAS for certification as a potential ARChoices provider.

Arkansas Medicaid does not provide ARChoices Waiver services in non-bordering states.

201.105 Provider Assurances  10-1-16

A. Agency 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 an ARChoices Waiver Person-Centered Service Plan (PCSP).

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 Department of Human Services (DHS), Division of Aging and Adult Services (DAAS) Division of Provider Services and Quality Assurance (DPSQA), requires mandatory training. The provider must attend one of the two provider workshop trainings in the calendar year. “Provider” in this context means at least one provider representative who will be able to inform the rest of the provider staff of what was covered in training. Failure to attend one of these trainings could jeopardize the provider’s licensure or certification for the waiver. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS. Direct care workers must be trained prior to providing services to an ARChoices beneficiary.

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 is required to attend orientation training prior to allowing the employee to deliver any ARChoices Waiver service(s). This orientation shall include, but not be limited to:
   a. Description of the purpose and philosophy of the ARChoices 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 ARChoices Waiver record keeping requirements;
   e. Discussion of the importance of the PCSP;
   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;
   h. Discussion of the beneficiary’s rights regarding HCBS Settings as discussed in C of this section.

B. Code of Ethics

   The Provider agrees to follow and/or enforce for each employee providing services to an ARChoices Waiver beneficiary a written code of ethics 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 beneficiaries are to accompany the employee to beneficiary’s residence;
   6. No consumption of alcoholic beverages or use of non-prescribed drugs prior to or during service delivery;
   7. No smoking in the beneficiary’s residence;
   8. No solicitation of money or goods from the beneficiary;
   9. No breach of the beneficiary’s privacy or confidentiality of records.
C. Home and Community-Based Services (HCBS) Settings

All providers must meet the following Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the new rule is 42 CFR 441.301(c) (4)-(5).

Settings that are HCBS must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

HCBS settings must have the following characteristics:

1. Chosen by the individual from among setting options including non-disability specific settings (as well as an independent setting) and an option for a private unit in a residential setting.
   a. Choice must be identified and included in the PCSP.
   b. Choice must be based on the individual's needs, preferences and, for residential settings, resources available for room and board.

2. Ensures an individual’s rights of privacy, dignity and respect and freedom from coercion and restraint.

3. Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.

4. Facilitates individual choice regarding services and supports and who provides them.

5. The setting is integrated in and supports full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving Medicaid HCBS.

6. In a provider-owned or controlled residential setting (e.g., Adult Family Homes), in addition to the qualities specified above, the following additional conditions must be met:
   a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
   b. Each individual has privacy in their sleeping or living unit:
      i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
      ii. Beneficiaries sharing units have a choice of roommates in that setting.
      iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
   c. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
   d. Beneficiaries are able to have visitors of their choosing at any time.
e. The setting is physically accessible to the individual.

f. Any modification of the additional conditions specified in items 6.a. through 6.de. above must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:
   i. Identify a specific and individualized assessed need.
   ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
   iii. Document less intrusive methods of meeting the need that have been tried but did not work.
   iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
   vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   vii. Include the informed consent of the individual.
   viii. Include an assurance that interventions and supports will cause no harm to the individual.

**210.000 PROGRAM COVERAGE**

**211.000 Scope 1-1-16**

The Arkansas Medical Assistance (Medicaid) Program offers certain home and community-based outpatient services as an alternative to nursing home placement. These services are available to persons age 21 through 64 who are determined to have a physical disability through the Social Security Administration or the DHS Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or are 65 years of age or older and require an intermediate level of care in a nursing facility. The community-based services offered through the ARChoices Home and Community-Based Waiver, described herein as ARChoices, are as follows:

**Adult Family Homes**

A. Attendant Care Services
B. Home-Delivered Meals
C. Personal Emergency Response System
D. Adult Day Services
E. Adult Day Health Services
F. Prevocational Services
G. Respite Care
H. Environmental Accessibility Adaptations/Adaptive Equipment

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

In accordance with 42 CFR 441.301(b) (1) (ii) ARChoices services may not be provided to inpatients of nursing facilities, hospitals or other inpatient institutions except for inpatient respite services.
A. To qualify for the ARChoices Program, a person must be age 21 through 64 and have been determined to have a physical disability through the Social Security Administration or the Department of Human Services (DHS) Medical Review Team (MRT) and require an intermediate level of care in a nursing facility, or be 65 years of age or older and require an intermediate level of care in a nursing facility. Persons determined to meet the skilled level of care, as determined by the Office of Long Term Care, are not eligible for the ARChoices Program.

The beneficiary intake and assessment process for the ARChoices Program includes a determination of categorical eligibility, financial eligibility, a nursing facility level of care determination, the development of a PCSP and the beneficiary's notification of his or her choice between home and community-based services and institutional services.

The ARChoices Program processes for beneficiary intake, assessment, and service plan development include:

1. Determination of categorical eligibility;
2. Determination of financial eligibility;
3. Determination of nursing facility level of care;
4. Development of a person-centered service plan (PCSP);
5. Development of an individual services budget (ISB);
6. Notification to the beneficiary of his or her choice between home- and community-based services and institutional services; and
7. Choice by the beneficiary among certified providers.

B. Applicants for participation in the program (or their representatives) must make application for services at the DHS office in the county of their residence. Medicaid eligibility is determined by the DHS Division of County Operations county office, the results of the independent assessment, and the DAAS Long-Term Services and Supports (LTSS) Program DPSQA Office of Long Term Care (OLTC) Eligibility Specialist, and is based on non-functional and functional criteria. Income and resources comprise the non-functional criteria. The individual must be an individual with a functional need.

C. To be determined an individual with a functional need; 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. Functional assessment results in a score of three or more on Cognitive Performance Scale. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,
3. Functional assessments results in a Change in Health, End-Stage Disease and Signs and Symptoms (CHESS) score of three or more. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

4. Definitions:
   a. CHESS means the Changes in Health, End-Stage Disease, Signs and Symptoms Scale was designed to identify individuals at risk of serious decline. It can serve as an outcome where the objective is to minimize problems related to declines in function, or as a pointer to identify persons whose conditions are unstable. CHESS, originally developed for use with nursing home residents, has been adapted for use with other instruments in the interRAI suite. It creates a 6-point scale from 0 = not at all unstable to 5 = highly unstable, with higher levels predictive of adverse outcomes such as mortality, hospitalization, pain, caregiver stress and poor self-rated health. (RE: http://www.interrai.org/scales.html)
   b. COGNITIVE PERFORMANCE SCALE (CPS) combines information on memory impairment, level or consciousness and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). The CPS has been shown to be highly correlated with the MMSE in a number of validation studies. (RE: http://www.interrai.org/scales.html)
   c. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.
   d. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.
   e. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.
   f. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.
   g. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.
   h. INTELLECTUAL AND DEVELOPMENTAL DISABILITIES means a level of intellectual disability as described in the American Association on Intellectual and Developmental Disabilities’ Manual on Intellectual Disability: Definition Classification, and systems and supports. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.
   i. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.
   j. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care;
and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice and in terms of duration and amount.

i. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.

ii. Intravenous injections and hypodermoclysis or intravenous feedings.

iii. Levin tubes and nasogastric tubes.

iv. Nasopharyngeal and tracheostomy aspiration.

v. Application of dressings involving prescription medication and aseptic techniques.

vi. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.

vii. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.

viii. Initial phases of a regimen involving administration of medical gases.

ix. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.

x. Ventilator care and maintenance.

xi. The insertion, removal and maintenance of gastrostomy feeding tubes.

k. **SUBSTANTIAL SUPERVISION** means the prompting, reminding or guidance of another person to perform the task.

l. **TOILETING** means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.

m. **TOTAL DEPENDENCE** means the individual needs another person to completely and totally perform the task for the individual.

n. **TRANSFERRING** means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

D. Individuals who require a skilled level of care as defined in Department of Human Services regulations are not eligible for the ARChoices waiver.

E. The Arkansas Independent Assessment (ARIA) is the assessment instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan. The ARIA system assigns tiers designed to help further differentiate individuals by need. Each waiver applicant or participant is assigned a tier level (0, 1, 2, or 3) following each assessment or re-assessment. The tiers are intended to help inform waiver program oversight and
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ARChoices In Homecare Home and Community-Based 2176 Waiver

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administration and person-centered service planning. Tier levels are also a population-based factor used in determining participants’ prospective individual services budgets. The tiers do not replace the Level of Care criteria described in Section C above, waiver eligibility determinations, or the person-centered service plan process.

1. Tier 0 (zero) and Tier 1 (one) indicate the individual’s assessed needs, if any, do not support the need for either ARChoices waiver services or nursing facility services.

2. Tier 2 (two) indicates the individual’s assessed needs are consistent with services available through either the ARChoices waiver program or a licensed nursing facility.

3. Tier 3 (three) indicates the individual needs skilled care available through a licensed nursing facility and therefore is not eligible for the ARChoices waiver program.

These indications notwithstanding, the final determination of Level of Care and functional eligibility is made by the Office of Long-Term Care (OLTC).

For more information on ARIA, please see the ARIA Manual.

DF. 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 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.

EG. Beneficiaries diagnosed with a serious mental illness or intellectual disability are not eligible for the ARChoices Program unless they have medical needs unrelated to the diagnosis of mental illness or intellectual disability and meet the other qualifying criteria. A diagnosis of severe mental illness or intellectual disability must not bar eligibility for beneficiaries having medical needs unrelated to the diagnosis of serious mental illness or intellectual disability when they meet the other qualifying criteria.

FH. Eligibility for the ARChoices Waiver program begins the date the DHS Division of County Operations county office DAAS LTSS Program Specialist approves the application unless there is a provisional plan of care. (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.)

GI. The ARChoices Waiver provides for the entrance of all eligible persons on a first-come, first-served basis, once beneficiaries meet all functional and financial eligibility requirements. However, the waiver dictates a maximum number of unduplicated, and active, beneficiaries who can be served in any waiver year. Once the maximum number of unduplicated, or active, 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 ARChoices 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.

**212.050 Definitions**

A. **ARIA ASSESSMENT TOOL** means the Arkansas Independent Assessment (ARIA) instrument used by registered nurses of the Independent Assessment Contractor to collect information used in determining level of care and developing the person-centered service plan.

B. **DHS RN** means a registered nurse authorized by DHS to develop the person-centered service plan for a participant.

C. **EATING** means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.

D. **EXTENSIVE ASSISTANCE** means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

E. **INDEPENDENT ASSESSMENT CONTRACTOR** means the DHS vendor responsible for administering the ARIA assessment tool for the purpose of collecting information used in determining level of care and developing the person-centered service plan.

F. **LICENSED MEDICAL PROFESSIONAL** means a licensed nurse, physician, physical therapist, or occupational therapist.

G. **LIMITED ASSISTANCE** means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

H. **LOCOMOTION** means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

I. **INTELLECTUAL AND DEVELOPMENTAL DISABILITIES** means a level of intellectual disability as described in the American Association on Intellectual and Developmental Disabilities’ Manual on Intellectual Disability: Definition Classification, and systems and supports. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

J. **PCSP** means a person-centered service plan.

K. **SERIOUS MENTAL ILLNESS OR DISORDER** means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 CFR § 483.100 - 102, Subpart C - Preadmission Screening and Annual Resident Review (PASARR) of Individuals with Mental Illness and Intellectual Disability.

L. **SKILLED LEVEL OF CARE** means the following services when delivered by licensed medical personnel in accordance with a medical care plan requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual’s illness or injury, i.e., be consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, accepted standards of medical practice and in terms of duration and amount.
1. Intermuscular or subcutaneous injections if the use of licensed medical personnel is necessary to teach an individual or the individual's caregiver the procedure.

2. Intravenous injections and hypodermoclysis or intravenous feedings.

3. Levin tubes and nasogastric tubes.

4. Nasopharyngeal and tracheostomy aspiration.

5. Application of dressings involving prescription medication and aseptic techniques.

6. Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders that are in Stage III or Stage IV.

7. Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.

8. Initial phases of a regimen involving administration of medical gases.

9. Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.

10. Ventilator care and maintenance.

11. The insertion, removal and maintenance of gastrostomy feeding tubes.

M. SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.

N. TOILETING means the act of voiding of the individual's bowels or bladder and includes the use of a toilet, commode, bedpan or urinal; transfers on and off a toilet, commode, bedpan or urinal; the cleansing of the individual after the act; changes of incontinence devices such as pads or diapers; management of ostomy or catheters and adjustment to clothing.

O. TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.

P. TRANSFERRING means the act of an individual in moving from one surface to another and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids and chairs.

212.100 An Overview of Resource Utilization Groups (RUGs)

The ARChoices Waiver provides beneficiaries with a monthly allocation of attendant care hours to be used at the beneficiary's discretion throughout the month. The number of attendant care hours approved for each beneficiary is based on the results of that beneficiary's most recent assessment using the ArPath Assessment Tool.

The ArPath Assessment Tool uses a software program that includes an algorithm to evaluate certain responses within an extensive questionnaire to determine whether the beneficiary meets the functional eligibility criteria to participate in the waiver program. The ArPath Assessment Tool then uses another algorithm to evaluate other responses to determine which Resource Utilization Group (RUG) reflects the beneficiary's functional abilities. A RUG is a tier group consisting of individuals with similar functional abilities.

In 2013, attendant care services were determined based on an RN's discretionary interpretation of a beneficiary's responses to the ArPath Assessment Tool's questionnaire. Between 2013 and
January 1, 2016, when the ARChoices program was implemented, DAAS recorded beneficiary RUG placement and the number of paid attendant care hours utilized by beneficiaries each month in order to determine the type and amount of resources that beneficiaries with similar functional abilities were used in a given month.

While the reality of living with a disease or condition can vary greatly even among individuals with the same diagnosis, a RUG placement allows DAABHS to better predict the type and extent of care that an individual needs. The purpose of transitioning to a RUG-based care allocation system is to provide more predictable and objective outcomes that better reflect the reality of a beneficiary’s needs by organizing the allocation around functional ability.

As of January 1, 2016, the allocation of attendant care hours became based on which RUG the beneficiary is placed in by the ArPath Assessment Tool. The specific number of attendant care hours assigned to a particular RUG was determined by considering an average of the number of hours used by beneficiaries placed in that RUG prior to the implementation of the ARChoices program. The following chart shows the number of hours assigned to each RUG.

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<th>RUG Category</th>
<th>RUG</th>
<th>Monthly Hours</th>
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<td>Behavioral Problems</td>
<td>BB0</td>
<td>118</td>
</tr>
<tr>
<td></td>
<td>BA2</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>BA1</td>
<td>30</td>
</tr>
<tr>
<td>Reduced-Physical Function</td>
<td>PD0</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>PC0</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>PB0</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>PA2</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>PA1</td>
<td>28</td>
</tr>
</tbody>
</table>

**RUG Requirements**
The ArPath Assessment Tool evaluates the assessment responses using an algorithm, which is basically a “rule book” for the software. This particular rulebook is divided into chapters, known as screeners, and each screener is responsible for evaluating a small portion of the assessment responses in order to produce a numerical score. Below is a list of the screeners and the possible scores:

<table>
<thead>
<tr>
<th>Screener</th>
<th>Possible Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living (ADL)</td>
<td>4-18</td>
</tr>
<tr>
<td>Instrumental Activities of Daily Living (IADL)</td>
<td>0-3</td>
</tr>
<tr>
<td>Rehab</td>
<td>0-1</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>0-1</td>
</tr>
<tr>
<td>Extensive Care</td>
<td>0-1</td>
</tr>
<tr>
<td>Special Care</td>
<td>0-1</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td>0-1</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>0-1</td>
</tr>
<tr>
<td>Cumulative</td>
<td>0-5</td>
</tr>
</tbody>
</table>

Each RUG requires a different combination of screener scores in order for a beneficiary to be placed in that RUG. The ArPath Assessment Tool utilizes the criteria for each RUG in the exact order that they are listed in the above chart and it places the beneficiary in the first RUG on the list whose criteria are satisfied by the assessment responses.

The following is a description of the screener scores required for each Special Rehab RUG.
A. RB0 requires a Rehab screener score of 1 and an ADL score of at least 11.
B. RA2 requires a Rehab screener score of 1, an IADL score of at least 2, and an ADL score of no more than 10.
C. RA1 requires a Rehab screener score of 1, an IADL score of 1 or 0, and an ADL score of no more than 10.

The following is a description of the screener scores required for each Extensive Care RUG.
A. SE3 requires a Cumulative screener score of at least 4, an Extensive Care screener score of 1, and an ADL score of at least 7.
B. SE2 requires a Cumulative screener score of either 2 or 3, an Extensive Care screener score of 1, and an ADL score of at least 7.
C. SE1 requires a Cumulative screener score of no more than 1, an Extensive Care screener score of 1, and an ADL score of at least 7.

The following is a description of the screener scores required for each Special Care RUG.
A. SSB requires an ADL score of at least 14 and a score of 1 for either the Extensive Care screener or the Special Care screener.
B. SSA has two possible combinations:
1. An Extensive Care screener score of 1 with an ADL score of no more than 6, or
2. An ADL score within the range of 7-13 and a score of 1 for either the Extensive Care screener or the Special Care screener.

The following is a description of the screener scores required for each Clinically Complex RUG.

A. CC0 requires an ADL score of at least 11 and a score of 1 for either the Clinically Complex screener or the Special Care screener.

B. CB0 requires an ADL score within the range of 6-10 and a score of 1 for either the Clinically Complex screener or the Special Care screener.

C. CA2 requires an ADL score no higher than 5, an IADL score of at least 1, and a score of 1 for either the Clinically Complex screener or the Special Care screener.

D. CA1 requires an ADL score no higher than 5, an IADL score of 0, and a score of 1 for either the Clinically Complex screener or the Special Care screener.

The following is a description of the screener scores required for each Impaired Cognition RUG.

A. IB0 requires a Cognitive Impairment screener score of 1 and an ADL score within the range of 6-10.

B. IA2 requires a Cognitive Impairment screener score of 1, an IADL score of at least 1, and an ADL score of no more than 5.

C. IA1 requires a Cognitive Impairment screener score of 1, an IADL score of 0, and an ADL score of no more than 5.

The following is a description of the screener scores required for each Behavioral Problems RUG.

A. BB0 requires a Behavior Problems screener score of 1 and an ADL score within the range of 6-10.

B. BA2 requires a Behavior Problems screener score of 1, an IADL score of at least 1, and an ADL score of no more than 5.

C. BA1 requires a Behavior Problems screener score of 1, an IADL score of 0, and an ADL score of no more than 5.

The following is a description of the screener scores required for each Reduced Physical Function RUG.

A. PD0 requires a Rehab screener score of 0 and an ADL score of at least 11.

B. PC0 requires a Rehab screener score of 0 and an ADL score of 9 or 10.

C. PB0 requires a Rehab screener score of 0 and an ADL score of 6, 7, or 8.

D. PA2 requires a Rehab screener score of 0, an IADL score of at least 1, and an ADL score of no more than 5.

E. PA1 requires a Rehab screener score of 0, an IADL score of 0, and an ADL score of no more than 5.

Screener Requirements

Activities of Daily Living (ADL)
A beneficiary’s ADL score ranges from 4 to 18. It is based on the collective score among responses to the 5 items in the assessment that are listed below. Only 4 of the 5 responses will add to the overall ADL score because the response to Mode of nutritional intake may override the response to Eating.

A. Bed mobility
B. Transfer toilet
C. Toilet use
D. Eating
E. Mode of nutritional intake

Bed mobility, Transfer toilet, and Toilet use are all scored in the following way:

A. Independent gets 1 point,
B. Independent, set up help only gets 1 point,
C. Supervision gets 1 point,
D. Limited assistance gets 3 points,
E. Extensive assistance gets 4 points,
F. Maximal assistance gets 5 points,
G. Total dependence gets 5 points, and
H. Activity did not occur gets 5 points.

Eating is scored in the following way:

A. Independent gets 1 point,
B. Independent, set up help only gets 1 point,
C. Supervision gets 1 point,
D. Limited assistance gets 2 points,
E. Extensive assistance gets 3 points,
F. Maximal assistance gets 3 points,
G. Total dependence gets 3 points, and
H. Activity did not occur gets 3 points.

However, 3 points will be added to the ADL score, and the Eating score will be overridden if the response to Mode of nutritional intake is any of the following:

A. Combined oral and parenteral or tube feeding,
B. Nasogastric tube feeding only,
C. Abdominal feeding tube, or
D. Parenteral feeding tube only
E. Instrumental Activities of Daily Living (IADL)
A beneficiary’s IADL score ranges from 0 to 3. It is based on the collective score among the responses to the following items in the assessment:

A. Meal preparation-performance,
B. Managing medication-performance, or
C. Phone use-performance.

The responses to each item are scored in the following way.

A. Independent gets 0 points.
B. Independent, set up help only gets 0 points.
C. Supervision gets 0 points.
D. Limited assistance gets 0 points.
E. Extensive assistance gets 0 points.
F. Maximal assistance gets 1 point.
G. Total dependence gets 1 point.
H. Activity did not occur gets 1 point.

Rehab

A beneficiary’s Rehab screener score is 0 by default, but it equals 1 if during the week prior to the assessment the beneficiary spends a total of at least 120 minutes in any combination of the following types of therapy:

A. Speech-language pathology,
B. Occupational therapy, or
C. Physical therapy.

Behavior Problems

A beneficiary’s Behavior Problems score is 0 by default, but it equals 1 if the beneficiary has exhibited any of the following at any time within 3 days of the assessment:

A. Wandering,
B. Verbal abuse,
C. Physical abuse,
D. Socially inappropriate or disruptive behavior,
E. Resists care,
F. Delusions, or
G. Hallucinations.

Extensive Care

A beneficiary’s Extensive Care screener score is 0 by default, but it equals 1 if the response to Mode of nutritional intake is either Abdominal feeding tube or Parenteral feeding tube only. It will
also equal 1 if the assessment records that any of the following treatments have been utilized within 3 days of the assessment:

A. IV medication,

B. Suctioning,

C. Tracheostomy care, or

D. Ventilator or respirator.

Special Care

A beneficiary’s Special Care screener score is 0 by default, but it equals 1 if the assessment records that Radiation therapy has been utilized within 3 days of the assessment or any of the following combinations of responses are logged in the assessment:

A. A turning/repositioning program has been utilized within 3 days of the assessment and the response to Most severe pressure ulcer is either:
   1. Deep craters in the skin or
   2. Breaks in the skin exposing muscle or bone;

B. Aphasia has been exhibited within 3 days of the assessment and the Mode of nutritional intake is either:
   1. Nasogastric tube feeding or
   2. Combined oral and parenteral or tube feeding;

C. Wound care has been performed within 3 days of the assessment and the response to either of the following items is yes:
   1. Major skin problems or
   2. Skin tears or cuts;

D. Fever and Vomiting are exhibited within 3 days of the assessment;

E. Fever is exhibited within 3 days of the assessment and the response to Weight loss of 5% is yes;

F. Fever is exhibited within 3 days of the assessment and the response to Mode of nutritional intake is either:
   1. Nasogastric tube feeding or
   2. Combined oral and parenteral or tube feeding;

G. Fever is exhibited within 3 days of the assessment and the response to Pneumonia is any of the following:
   1. Primary diagnosis for current stay;
   2. Diagnosis present, receiving active treatment; or
   3. Diagnosis present, monitored but no active treatment;

H. Fever is exhibited within 3 days of the assessment and the response to Dehydration is yes; or

I. A beneficiary’s ADL score is at least 10 and the response to either Multiple sclerosis or Quadriplegia is any of the following:
   1. Primary diagnosis for current stay;
2. Diagnosis present, receiving active treatment; or
3. Diagnosis present, monitored but no active treatment.

Clinically Complex

A beneficiary’s Clinically Complex screener score is 0 by default, but it equals 1 if any of the following is recorded during the assessment:

A. Mode of nutritional intake is either Nasogastric tube feeding or Combined oral and parenteral or tube feeding;
B. The response to Cognitive skills for daily decision making is No discernable consciousness, coma and the response to any of the following is either Total dependence or Activity did not occur:
   1. Bed mobility,
   2. Transfer, toilet,
   3. Toilet use, or
   4. Eating;
C. Any form of Sepsis is recorded in the Other Diseases section of the assessment;
D. The response to Dehydration is yes;
E. The beneficiary’s ADL score is at least 10 and the response to Hemiplegia is any of the following:
   1. Primary diagnosis for current stay;
   2. Diagnosis present, receiving active treatment; or
   3. Diagnosis present, monitored but no active treatment;
F. GI or GU bleeding has been exhibited in the 3 days prior to the assessment;
G. The response to Pneumonia is any of the following:
   1. Primary diagnosis for current stay;
   2. Diagnosis present, receiving active treatment; or
   3. Diagnosis present, monitored but no active treatment;
H. The response to End stage disease, 6 or fewer months to live is yes;
I. Chemotherapy was utilized within 3 days of the assessment;
J. Dialysis was utilized within 3 days of the assessment;
K. A transfusion occurred within 3 days of the assessment;
L. Oxygen therapy was utilized within 3 days of the assessment; or
M. The response to Foot problems is either Foot problems limit walking or Foot problems prevent walking.

Impaired Cognition

A beneficiary’s Impaired Cognition screener score is 0 by default, but it equals 1 if the score recorded on the Cognitive Performance Scale (CPS) is at least a 3.

Cumulative
A beneficiary’s Cumulative screener score can range from 0 to 5. It is based on the collective score after adding the scores from the Special Care, Clinically Complex, and Impaired Cognition screeners. An additional point may be added if either of the following occurs:

A.— The response to Mode of nutritional intake is Parenteral feeding only or

B.— IV medication is utilized within 3 days of the assessment.

212.200 Prospective Individual Services Budget

A. Individual Services Budget (ISB):

1. In the ARChoices in Homecare program, there is a limit on the maximum dollar amount of waiver services that may be authorized for or received by each specific participant. This limit is called the Individual Services Budget (ISB) and applies to all participants and all waiver services available through the ARChoices program.

2. Each ARChoices person-centered service plan shall include an Individual Services Budget, as determined by DAABHS for the specific participant during the service plan development process. The projected total cost of all authorized services in any ARChoices person-centered service plan (including provisional plans) shall not exceed the participant’s Individual Services Budget applicable to the time period covered by the service plan.

3. Each participant’s Individual Services Budget shall be explained when the DHS RN consults with the individual on the person-centered service plan. This may be done through written information.

4. Each participant shall also receive written notice of their Individual Services Budget that includes notice of the right to request a Fair Hearing if they are denied waiver services as a result of a dollar limit.

B. Adjustments, Considerations, and Safeguards Regarding Individual Services Budgets:

1. During the development of each person-centered service plan, after considering the participant’s assessed needs, priorities, preferences, goals, and risk factors, and to ensure that the cost of all ARChoices services for each participant does not exceed the applicable Individual Services Budget amount, the DHS RN shall, as necessary:

   a. Limit and modify the type, amount, frequency, and duration of waiver services authorized for the participant (notwithstanding any service-specific limits established in Appendix C: Participant Services); and

   b. Make referrals to appropriate services available through the Medicaid State Plan or another waiver program, Medicare, the participant’s Medicare Advantage (MA) plan (including targeted and other supplemental benefits the MA plan may offer), the participant’s Medicare prescription drug plan, and other federal, state, or community programs.
2. Should the DHS RN determine that the ARChoices waiver services authorized for the participant within the limit of the applicable Individual Services Budget, other Medicaid or Medicare covered services, and other available family and community supports, when taken together, are insufficient to meet the participant's needs, the DHS RN shall counsel the participant on Medicaid-covered services in other settings that are available to meet their needs (e.g., nursing facility services and assisted living facility services) and make appropriate referrals. The DHS RN may also order a re-assessment of the participant.

3. In the event that a participant's ISB requires changes or limitations to ARChoices services (that otherwise could be authorized for the person in the absence of the ISB) to ensure that the applicable ISB amount is not exceeded, during the person-centered service plan process the participant will be given the opportunity to choose a different mix, type, or amount of ARChoices covered services. (For example, the participant could decide to forego a day of adult day health services in order to have additional attendant care hours.) Any such participant-requested changes and substitutions are subject to the following:
   a. The services chosen by participant are otherwise covered and reimbursable under ARChoices and do not exceed any applicable service limitations;
   b. The services chosen by participant are necessary and appropriate for the individual and consistent with the results of the independent assessment;
   c. The cost of all ARChoices waiver services authorized for or received by the participant, including any participant-requested changes and substitutions, do not exceed the applicable ISB amount; and
   d. The DHS RN determines the changes are reasonable and necessary for the individual and reflected in the approved person-centered service plan.

4. If waiver services are or become limited due to the application of the Individual Services Budget, the affected participant may request an exception in the form of a temporary increase in the person's ISB amount applicable to a period not to exceed one year. Exception requests shall be reviewed and acted on by DAABHS using a panel of at least three registered nurses. This exceptions process is intended as a safeguard to address exceptional circumstances affecting a participant's health and welfare and not as means to circumvent the application of the Individual Services Budget policy or permit coverage of services not otherwise medically necessary for the individual, consistent with their level of care, assessment results, and waiver program policy. Approval of an exception request and associated temporary increase in a participant's Individual Services Budget amount for a period not to exceed one year is subject to the following criteria:
   a. In the professional opinion of the nurse panel, unique circumstances indicate that additional time is reasonably needed by the participant (or the participant's family on his or her behalf) to (1) adjust waiver service use costs to within the applicable Individual Services Budget (ISB) amount, (2) arrange for the start of or increase in non-Medicaid services (such as informal family supports and Medicare-covered services), and/or (3) arrange for placement in an alternative residential or facility-based setting.
   b. Such unique circumstances must be (1) specific to the individual; (2) supported by documentation provided to the nurse panel; (3) relevant to the individual's assessed needs and risk factors; (4) relevant to the temporary need for additional, medically necessary coverable waiver services in excess of the person's pre-exception ISB amount; and (5) not the result of a need for skilled services or other services not covered under the waiver.
c. Such unique circumstances may include (1) recent major life events not known at the
time the current person-centered service plan was approved, including without
limitation death of a spouse or caregiver, and loss of a home or residential
placement; and (2) A temporary increase in care needs, for a period not to exceed
ninety (90) days after a discharge from inpatient acute treatment or post-acute care.

d. If the exception request is due to the participant (or participant’s family on his or her
behalf) encountering delays or difficulties in arranging new care arrangements or an
alternative residential or facility-based placement in the state, an exception may be
granted if the nurse panel determines reasonable efforts are being made and the
delays or difficulties experienced are exceptional or due to rural or remote location of
the participant’s home.

e. The factors considered by the nurse panel must be reasonably relevant to the
necessity for additional waiver services in total cost in excess of the person’s pre-
exception ISB amount and for a temporary period of time not to exceed one year.

5. If the projected cost of services identified in an individual’s person-centered service plan
(whether such plan is under development, provisional, or final or renewed, amended, or
extended) is less than the applicable Individual Services Budget amount, this shall not be
construed to permit, suggest, or justify approval, coverage, or reimbursement of different or
additional waiver services (including changes in amount, frequency, or duration); coverage
and reimbursement of any medically unnecessary Medicaid State Plan or waiver services; or
other actions to increase spending to use the remaining “unused” portion of the ISB amount.

6. The Individual Services Budget shall not apply to environmental accessibility
adaptations/adaptive equipment.

C. Transition Process:

1. The Individual Services Budget limit shall apply to the following:

   a. New ARChoices participants, including individuals determined newly eligible for
ARChoices following a period of ineligibility for this or another HCBS waiver
program, when they are determined waiver eligible, and effective for their first
person-centered service plan and thereafter; and

   b. Existing ARChoices participants immediately upon any of the following events,
whichever may occur first:

      i. Waiver eligibility is re-evaluated;

      ii. The Level of Care is reaffirmed or revised;

      iii. A new independent assessment or re-assessment is performed;

      iv. Expiration, renewal, extension, or revision of the participant’s person-
centered service plan occurs; or

      v. Admission to or discharge from an inpatient hospital, nursing facility, assisted
living facility, or residential care facility, or transfer from a hospice facility
occurs.

2. For all other ARChoices participants not otherwise identified above, the Individual Services
Budget limit shall apply no later than 60 days after the effective date of this waiver
amendment.
3. For the following ARChoices participants, the DAABHS deputy director (or his/her designee) may on a case-by-case basis extend the effective date of the participant’s first Individual Services Budget by a maximum of 60 days per participant upon written request of the participant (or legal representative) or the participant’s personal physician, if:

i. The specific participant’s recent pattern of waiver service expenditures exceeds the average Individual Services Budget amount by an estimated twenty-five (25) percent or more; and/or

ii. DAABHS determines that unique, intervening circumstances indicate that additional time is reasonably needed by the participant and the participant’s family and providers. Examples of unique, intervening circumstances include the death of the spouse, loss of home, or unexpected difficulties in accessing or arranging care or placement, among others.

D. Methodology for Determining Individual Services Budgets:

1. The Individual Services Budget amount for a participant is based on that participant’s ISB Level. The ISB Level is determined by DAABHS based on a review of the participant’s Independent Assessment. The three ISB Levels are:

a. Intensive: The participant requires total dependence or extensive assistance from another person in all three areas of mobility, feeding, and toileting.

b. Intermediate: The participant requires total dependence or extensive assistance from another person in two of the areas of mobility, feeding, or toileting.

c. Preventative: The participant meets the functional need eligibility requirements for ARChoices in Section 212.000 but does not meet the criteria for the ISB Levels of Intensive or Intermediate.

2. The maximum Individual Services Budget for a participant, except as modified by the Transitional Allowance in subsection (3) below, is as follows:

a. For an individual with an assessed ISB Level of Intensive, the Individual Services Budget is $30,000 annually.

b. For an individual with an assessed ISB Level of Intermediate, the Individual Services Budget is $20,000 annually.

c. For an individual with an assessed ISB Level of Preventative, the Individual Services Budget is $5,000 annually.

3. For a participant with total waiver expenditures of more than $30,000 for calendar year 2018:

a. The participant will be granted a Transitional Allowance for one year, increasing the participant’s maximum Individual Services Budget to the amount of the participant’s total waiver expenditures for calendar year 2018.

b. In the year following the Transitional Allowance, the participant’s maximum Individual Services Budget will be 95% of the participant’s total waiver expenditures for calendar year 2019.

c. For purposes of this subsection (3), “total waiver expenditures” for a calendar year shall be calculated as the sum total of the value of all waiver services authorized for the participant in the person-centered service plan as of December 31, and then modified by:
i. If the cumulative expenditures are for less than 12 months, annualizing the total to reflect what the expenditures would have been if the participant had received the same monetary amount of services for 12 consecutive months; and

ii. Excluding amounts expended for environmental accessibility adaptations/adaptive equipment services.

4. For purposes of determining the projected cost of all waiver services in an individual’s person-centered service plan, DAABHS shall assume that:
   a. The individual will receive or otherwise use all services identified in the service plan and in their respective maximum authorized amounts, frequencies, and durations; and
   b. There are no interruptions in the provision of waiver services due to possible future events such as an inpatient admission, nursing facility admission, or short-term admission to another facility setting.

212.300 Person-Centered Service Plan (PCSP)

A. Each beneficiary in the ARChoices Program must have an individualized ARChoices PCSP. The authority to develop an ARChoices PCSP is given to the Medicaid State agency’s designee, the DHS RN Division of Aging and Adult Services (DAAS) Registered Nurse (DAAS RN). At the discretion of the beneficiary, the ARChoices PCSP is developed with the ARChoices beneficiary, representative, the participant’s family or anyone requested by the participant, including the provider, if requested by the beneficiary. At the request of the beneficiary or their representative, the DAASDHS RN can assist in coordinating and inviting any requested beneficiaries.

B. When developing the waiver PCSP, the beneficiary may freely choose a family member or individual to appoint as a representative. The beneficiary and representative may participate in all decisions regarding the types, amount and frequency of services included in the PCSP. The representative may participate in choosing the provider(s) for the beneficiary. If anyone other than the beneficiary chooses the provider, the DAASDHS RN will identify that individual on the PCSP. Should the self-directed service delivery model be selected by an individual other than the beneficiary, that individual may not be the paid employee for one year unless the DAAS approves a release based upon extenuating circumstances and in the best interest of the beneficiary.

C. The ARChoices PCSP developed by the DAASDHS RN includes, but is not limited to:
   1. Beneficiary identification and contact information, including full name and address, phone number, date of birth, Medicaid number and the effective date of ARChoices Waiver eligibility;
   2. Contact person;
   3. Physician’s name and address;
   4. The amount, frequency and duration of ARChoices Waiver services to be provided and the name of the service provider chosen by the beneficiary or representative to provide the services. **Note:** Attendant Care, Respite Care, and State Plan Personal Care hours are authorized on the waiver PCSP based on the number of hours calculated by application of the Arkansas Medicaid Task and Hour Standards (THS) which is described below in Section D a Resource Utilization Group (RUG) score produced from the ArPath assessment. Attendant Care, Respite Care, and State Plan Personal Care hours are authorized in a monthly amount on-in the waiver PCSP. The provider and beneficiary determine how to use the Attendant Care hours based on the beneficiary’s needs and preferences. The beneficiary’s chosen, Medicaid-certified provider is
responsible for properly delivering Attendant Care, Respite Care, and State Plan Personal Care services to support the needed activity of daily living (ADL) and instrumental activity of daily living (IADL) tasks, consistent with the approved PCSP, this manual, and other applicable Arkansas Medicaid policy.

5. Other services outside the ARChoices services, regardless of payment source, identified and/or ordered to meet the beneficiary’s needs including the option for the self-directed service delivery model;

6. The election of community services by the waiver beneficiary or representative; and,

7. The name and title of the DAASDHS RN responsible for the development of the beneficiary’s PCSP; and

8. The individual services budget for the participant.

D. Task and Hour Standards (THS):

1. Background on THS

The Arkansas Medicaid Task and Hour Standards (“THS”) is the written methodology used by the DHS RNs as the basis for calculating the number of Attendant Care, Respite Care, and State Plan Personal Care hours that are reasonable and medically necessary to perform needed ADL and IADL tasks.

The current DAABHS-approved THS is located on the web at [insert website address]

The THS includes the following four components, described in a grid format:

a. The participant’s Needs Intensity Score (0, 1, 2, or 3) for each task;

b. The number of minutes within the minute range for the Needs Intensity Score that are reasonable to perform the particular task at the respective Needs Intensity Score;

c. The frequency with which a task is necessary and reasonably performed; and

d. The amount of assistance with ADLs and IADLs provided by other sources, such as (A) informal caregivers (e.g., relatives, neighbors, and friends), (B) community-based agencies such as Meals on Wheels, and (C) Medicare or a Medicare Advantage health plan.

The THS provides a standardized process for calculating the amount of reasonable, medically necessary Attendant Care, Respite Care, and State Plan Personal Care services hours, with the minute ranges and frequencies providing DHS nurses with the ability to adjust PCSPs based on unique factors related to a given beneficiary’s needs, preferences, and risks.

The number of Attendant Care, Respite Care, and State Plan Personal Care hours/minutes that are authorized for each necessary task by week/month are calculated by the DHS RN consistent with the THS grid and based on:

a. Responses by the participant and their representatives to certain relevant questions in the ARIA assessment instrument, and

b. As appropriate, information obtained by the DHS RN during their PCSP meeting with the participant and participants’ representatives or from participant’s physician.

The Arkansas THS methodology has been reviewed and approved by DHS nurse leadership and is based on Texas Form 2060 Task/Hour Guide, which has been used to determine personal attendant service hours in Texas Medicaid home and community-based services programs for over 20 years.

The Arkansas THS is also used to calculate the reasonable quantity of hours to perform medically necessary tasks covered under IndependentChoices self-directed personal assistance or State Plan personal care services for adults aged 21 or older.
DAABHS will periodically review the THS grid and may revise it based on, for example, experience; information from the ARIA assessments and electronic visit verification system; DPSQA audits of providers; and beneficiary and provider feedback. These revisions could result in different, broader, or narrower minute ranges, frequencies per task type, and Needs Intensity Scores.

2. Needs Intensity Score:

For each task, the DHS RN will assign a Needs Intensity Score to the participant based on the participant’s and/or representative’s responses to questions during the ARIA assessment and information collected by the DHS RN during the PCSP meeting with the participant. The four Impairment Scores are defined as follows:

- Needs Intensity Score 0 – The participant has no functional impairment with regard to the task and can perform it without assistance.
- Needs Intensity Score 1 (Mild): Minimal/mild functional impairment. The participant is able to conduct activities with minimal difficulty and need minimal assistance.
- Needs Intensity Score 2 (Severe): Extensive/severe functional impairment. The participant has extensive difficulty carrying out activities and needs extensive assistance.
- Needs Intensity Score 3 (Total): The participant is completely unable to carry out any part of the activity.

A Needs Intensity Score is separate and distinct from a Tier Level under the ARIA system.

3. Number of minutes allowed for each Needs Intensity Score for each task

The THS grid specifies a minute range for each Needs Intensity Score for each task. For example, for the bathing task, at Needs Intensity Score 2 the minute range is 15-20 minutes, and the minute range for the grooming task at Needs Intensity Score 1 is 10-20 minutes. The DHS RN preparing the PCSP will determine the number of minutes within the range that are appropriate for the participant based on conditions specific to the participant. For example, if a participant has cognitive or behavioral issues, the DHS RN may find that the maximum number of minutes in the range for bathing is warranted. On the other hand, assigning the maximum number of minutes for grooming might not be appropriate for a participant who is bald.

If the participant has extenuating circumstances and requires time outside the range (either more or less) for the task, the DHS RN must obtain supervisory approval. For supervisory approval, the DHS RN must document the participant’s extenuating circumstances and justify the need for minutes outside the range. The justification of need must be based solely on the participant’s assessed or observed medical needs, and may not be for the convenience of a service provider or attendant. The request must be in writing (written or email) and the supervisor’s approval or disapproval must be in writing. If the extenuating circumstances are expected to be temporary, the PCSP must identify a date by which the deviation from the minute range will cease. Documentation of the request and the approval/disapproval must be filed with the PCSP.

4. The frequency with which a task is performed

The THS methodology takes into account the frequency with which each ADL and IADL is performed and reasonably necessary. The frequency with which a given task is performed for a beneficiary will be determined based on the ARIA assessment results and information collected by the DHS RN during the PCSP meeting with the participant.

5. The amount of assistance with ADLs and IADLs provided by other sources

ARChoices does not cover assistance that is needed but provided by other sources. Therefore, the THS grid includes fields, by task, for the number of minutes of support provided by other sources.
If instances of a needed assistance with an ADL or IADL are generally provided through another source, then ARChoices attendant care is not necessary and no time for that task is included in the PCSP. When another source is available to provide assistance with a needed ADL or IADL task, the time associated with the assistance from that other source is deducted from the total minutes per week.

The amount of support with ADLs and IADLs provided by other sources is informed by the ARIA assessment results and information gathered by the DHS RN during the PCSP meeting with the participant.

Other sources include informal caregivers (e.g., daughter or neighbor), community-based services such as Meals on Wheels, and services available through Medicare (e.g., Medicare home health aide services) or a Medicare Advantage health plan (e.g., supplemental services). Other support is calculated for each task based on how much support is provided with the task. For example, the participant’s daughter may bathe her mother once a week and prepare all meals on weekends, eliminating the need for an attendant care aide to perform those tasks. For this participant, the total minutes per week for the tasks of bathing and meal preparation would be adjusted by the minutes associated with an aide assisting with one bath and six meals per week.

6. Calculation of total hours of attendant care per month

The final step in the methodology is to add up the total minutes per week for each task. That total is converted to hours per week by dividing the number of minutes by 60. Monthly total hours can be calculated by multiplying the total weekly hour amount by 4.334. This monthly hourly value is the maximum number of attendant care hours approved for the participant for a month. The projected total cost of attendant care plus all other authorized services in the PCSP (including provisional plans) shall not exceed the participant’s Individual Services Budget applicable to the time period covered by the service plan.

E. If waiver eligibility is approved by the DHS Division of County Operations county office, and the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist, a copy of the PCSP signed by the DAASDHS RN and the waiver beneficiary or representative, will be forwarded to the beneficiary or representative and the Medicaid enrolled service provider(s) included in the PCSP. The service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Services cannot begin until the Medicaid provider receives the authorized PCSP from the DAASDHS RN. The original PCSP will be maintained by the DAASDHS RN.

The implementation of the PCSP by a provider must 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 authorized and reported by the DAASDHS RN regarding the waiver PCSP;
5. Provided within a system that safeguards the beneficiary’s rights to quality services as authorized on the waiver PCSP; and,
6. Documented carefully, with assurance that required information is recorded and maintained.

NOTE: Each service included on the ARChoices PCSP must be justified by the DAASDHS RN. This justification is based on medical necessity, the beneficiary’s physical, cognitive and functional status, other support services available to the beneficiary and other factors deemed appropriate by the DAASDHS RN.
Each ARChoices service must be provided according to the beneficiary PCSP. For services included in the waiver PCSP, Medicaid reimbursement is limited to the amount and frequency that is authorized in the PCSP, subject to the participant’s individual services budget. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

NOTE: PCSPs are updated annually by the DAASDHS RN and sent to the ARChoices provider prior to the expiration of the current PCSP. However, the provider has the responsibility for monitoring the PCSP expiration date and ensuring that services are delivered according to a valid PCSP. At least 30 and no more than 45 days before the expiration of each PCSP, the provider shall notify the DAASDHS RN via email and copy the RN supervisor of the PCSP expiration date.

Services are not compensable unless there is a valid and current PCSP in effect on the date of service.

REVISIONS TO A BENEFICIARY PCSP MAY ONLY BE MADE BY THE DAASDHS RN.

NOTE: All revisions to the waiver PCSP must be authorized by the DAASDHS RN. A revised PCSP will be sent to each appropriate provider. Regardless of when services are provided, unless the provider and the service are authorized on an ARChoices PCSP, services are considered non-covered and do not qualify for Medicaid reimbursement. Medicaid expenditures paid for services not authorized on the ARChoices PCSP are subject to recoupment.

All revisions to the PCSP must be consistent with and not exceed the participant’s applicable individual services budget.

212.305 Targeted Case Management Services (Non-Waiver Service) 1-1-16

Each ARChoices PCSP will include Targeted Case Management, unless refused by the waiver beneficiary. The Targeted Case Manager is responsible for monitoring the beneficiary’s status on a regular basis for changes in their service need, referring the beneficiary for reassessment, if necessary, and reporting any beneficiary complaints and changes in status to the DAASDHS RN or Nurse Manager immediately upon learning of the change.

NOTE: As stated in this manual, the service provider and the ARChoices beneficiary must review and follow the signed authorized PCSP. Each service included on the ARChoices PCSP must be justified by the DAASDHS 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 DAASDHS RN.

For ARChoices beneficiaries whose waiver PCSP includes TCM at the time the DAASDHS RN signs the PCSP, the ARChoices PCSP, signed by a DAASDHS RN, will serve as the authorization for TCM services for one year from the date of the DAASDHS RN's signature, as described above.

212.310 Provisional Person-Centered Service Plan (PCSP) 10-1-16

The ARChoices registered nurse (DAASDHS RN) may develop a provisional PCSP prior to establishment of Medicaid eligibility, based on information obtained during the in-home functional assessments administered by the Independent Assessment Contractor and the DHS RN, when recommending functional approval based on the nursing home criteria. The DAASDHS RN must discuss the provisional PCSP policy and have the approval of the applicant prior to completing and processing the provisional PCSP. The PCSP will be developed by the applicant and the DAASDHS RN and signed by the applicant or the applicant’s representative and the DAASDHS RN.
The provisional PCSP will include all current PCSP information, except for the waiver eligibility date and the Medicaid beneficiary ID number.

The provisional PCSP will be mailed to the waiver applicant and each provider included on the PCSP. If the beneficiary and the provider accept the risk of ineligibility, the provider must begin services within an established time frame as determined by the Division of Aging and Adult Services (DAAS) Division of Aging, Adult, and Behavioral Health Services (DAABHS) and notify the DAASDHS RN, via Start Services form AAS-9510, that services have started. The DAASDHS RN will track the start of care dates and give the applicant options when services are not started.

The provisional PCSP will expire 60 days from the date signed by the applicant and the DAASDHS RN. A PCSP that has been approved with a Medicaid number and waiver eligibility date must be in place no later than the expiration date of the provisional PCSP.

A. A provisional PCSP may be developed and sent to providers only when the assessment outcome indicates functional eligibility and the DAAS DPSQA-Office of Long Term Care determines based on the results of the ARIA assessment, believes, in his or her professional judgment, that the applicant meets the level of care criteria for an adult with a functional need, as explained in Section 212.000, Eligibility for the ARChoices Program.

The waiver eligibility date will be established retroactively, effective on the day the provisional PCSP was signed by the applicant or applicant’s representative and the DAASDHS RN, if:

1. At least one waiver service begins within 30 days of the development of the provisional PCSP
   AND
2. The waiver application is approved by the Division of County Operations.

B. If waiver services begin within 31 through 60 days of the development of the provisional PCSP, the retroactive eligibility date will be the effective date that a waiver service is started.

C. If waiver services do not begin within 60 days from the date the provisional PCSP is signed by the DAASDHS RN, the DHS Division of County Operations county office, DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist will establish the waiver eligibility date as the date the application is entered into the system as an approved application. There will be no retroactive eligibility.

D. Provisional PCSPs are subject to the participant’s individual services budget.

E. Provisional PCSPs may not include the non-waiver self-directed service delivery model.

212.311 Denied Eligibility Application 10-1-16

A. If the DHS Division of County Operations county office, and the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist 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 DHS Division of County Operations county office DAAS LTSS Program Eligibility Specialist will notify the DAASDHS RN. The DAASDHS 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 applicant 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 DHS Division of County Operations county office are as follows:

1. If the individual has no unpaid ARChoices 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 DHS Division of County Operations county office and the DAAS LTSS Program Eligibility Specialist completes the case.

2. If the individual has unpaid waiver charges and services were authorized by the DAASDHS 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 PCSP is signed by the DAASDHS RN and the applicant or the applicant’s representative, whichever is later.

212.312 Comprehensive Person-Centered Service Plan (PCSP) 10-1-16

Prior to the expiration date of the provisional PCSP, the DAASDHS RN will send the comprehensive PCSP to the waiver beneficiary and all providers included on the PCSP. The comprehensive PCSP will replace the provisional PCSP. The comprehensive PCSP will include the Medicaid beneficiary ID number, the waiver eligibility date established according to policy and the comprehensive PCSP expiration date.

The comprehensive PCSP expiration date will be 365 days from the date of the DAASDHS RN’s signature on form AAS-9503, the ARChoices PCSP. Once the application is either approved or denied by the DHS Division of County Operations county office, DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist, the providers will be notified by the DAASDHS RN. The notification for the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

212.313 ARChoices Applicants Leaving an Institution 1-1-16

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

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

NOTE: For inpatients, if a waiver application is filed at the local DHS Division of County Operations county office, prior to discharge AND if a provisional PCSP is developed by the DAASDHS RN prior to discharge, it may be possible to establish retroactive eligibility back to the date the applicant returned to his or her home if the applicant is ultimately found eligible for the program. (Note: Medicaid beneficiaries in nursing facilities do not have to complete a new application when applying for ARChoices. Their signature on the PCSP electing waiver services serves as the application.)
If no waiver application is filed and no functional assessment or provisional PCSP is completed by the Independent Assessment Contractor and DAASDHS RN prior to an applicant’s discharge from an institution, retroactive eligibility will not be possible back to the date the applicant returned to his home.

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

This policy applies to applicants leaving hospitals or nursing facilities.

212.320 Authorization of The ARChoices Person-Centered Service Plan (PCSP) with Personal Care Services

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

A. The DAASDHS RN is responsible for developing an ARChoices PCSP that includes both waiver and non-waiver services. Once developed, the PCSP is signed by the DAASDHS RN authorizing the services.

B. A PCSP developed on or after the effective date of this Provider Manual may not include attendant care services unless the PCSP provides for at least 64 hours per month of personal care services. Attendant care services are intended to supplement personal care services available under the Medicaid state plan.

C. The ARChoices PCSP signed by the DAAS DHS RN will suffice as the "Personal Care Authorization" for services required in the Personal Care Program. The personal care service plan developed by the Personal care provider is still required.

The responsibility of developing a personal care service plan is not placed with the DAAS DHS RN. The personal care provider is still required to complete a service plan, as described in the Arkansas Medicaid Personal Care Provider Manual.

NOTE: For ARChoices participants who have chosen to receive their personal care services through the IndependentChoices Program, the ARChoices PCSP, signed by a DAASDHS RN, will serve as the authorization for personal care services for one year from the date of the DAASDHS RN’s signature, as described above.

D. The ARChoices PCSP is effective for one year, once signed by the DAAS DHS RN; the authorization for personal care services, when included on the ARChoices PCSP, will be for one year from the date of the DAAS RN’s signature, unless revised by the DAAS RN. If personal care services continue unchanged as authorized on the ARChoices PCSP, a new service plan is not required at the 6-month interval.

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 DAAS RN will be aware that the provider is serving the beneficiary. Preferably, the provider will place the information atop the refrigerator or under the phone the beneficiary uses, unless the beneficiary objects. If so, the provider will place the information in a location satisfactory to the beneficiary, as long as it is readily available to and easily accessible by the DAAS RN.
212.322 Revisions when the Person-Centered Service Plan (PCSP) Contains Personal Care Services

Requested changes to the personal care services included on the ARChoices PCSP may originate with the personal care RN or the DAAS RN, based on the beneficiary’s circumstances. Unless requested by an IndependentChoices beneficiary, the individual or agency requesting revisions to the Personal Care services on the ARChoices PCSP is responsible for securing any required signatures authorizing the change prior to the ARChoices PCSP being revised.

If revised by the DAAS RN, a copy of the revised ARChoices PCSP and a Start of Care Form (AAS-0510) will be mailed to the personal care provider within 10 working days after being revised. If authorization is secured by the Personal Care agency, a copy of the revised personal care order, signed by the physician, must be sent to the DAAS RN prior to implementing any revisions. Once received, the ARChoices PCSP will be revised accordingly within 10 working days of its receipt. If any problems are encountered with implementing the requested revisions, the DAAS 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 rests with the DAAS RN.

212.400 Temporary Absences from the Home

Once an ARChoices eligibility application has been approved, waiver services must be provided in a home and community-based services setting for eligibility to continue. Unless stated otherwise below, the DHS Division of County Operations county Department of Human Services (DHS) office must be notified immediately by the Division of Aging and Adult Services Registered Nurse (DAASDHS RN) when waiver services are discontinued and action will be initiated by the DAAS LTSS Program Eligibility Specialist DHS Division of County Operations county office to close the waiver case. Providers will be notified by the DAASDHS RN.

A. Absence from the Home due to Institutionalization

An individual cannot receive ARChoices Waiver services while in an institution. The following policy applies to any inpatient stay where Medicaid pays the facility for the date of admission, i.e., hospitals, nursing homes, rehab facilities, etc., for active waiver cases when the beneficiary is hospitalized or enters a nursing facility for an expected stay of short duration.

1. When a waiver beneficiary is admitted to a hospital, the DAAS LTSS Program Eligibility Specialist DHS Division of County Operations county office will not take action to close the waiver case unless the beneficiary does not return home within 30 days from the date of admission. If, after 30 days, the beneficiary has not returned home, the DAASDHS RN will notify the DAAS LTSS Program Eligibility Specialist DHS Division of County Operations county office and action will be initiated to close the waiver case.

2. If the DHS Division of County Operations county office becomes aware that a beneficiary has been admitted to a nursing facility and it is anticipated that the stay will be short (30 days or less), the waiver case will be closed effective the date of the admission, but the Medicaid case will be left open. When the beneficiary returns home, the waiver case may be reopened effective the date the beneficiary returns home. A new assessment and medical eligibility determination will not be required unless the last review was completed more than 6 months prior to the beneficiary’s admission to the facility.

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

Payment for ARChoices services may be allowed for the date of a beneficiary's admission to an inpatient facility if the provider can provide verification that services were provided before the beneficiary was admitted. In order for payment to be allowed, providers are responsible for obtaining the following:

- Copies of claim forms or timesheets listing the times that services were provided
- A statement from the inpatient facility showing the time that the beneficiary was admitted
- This information must be submitted to DAAS DAABHS within 10 working days of receiving a request for verification.

If providers are unable to provide proof that ARChoices services were provided before the beneficiary was admitted to the inpatient facility, then payments will be subject to recoupment. ARChoices services provided on the same day the beneficiary is discharged from the inpatient facility are billable when provided according to policy and after the beneficiary was discharged.

B. Absence due to Reasons Other than Institutionalization

When a waiver beneficiary is absent from the home for reasons other than institutionalization, the DAAS LTSS Program Eligibility Specialist DHS Division of County Operations county office will not be notified unless the beneficiary does not return home within 30 days. If, after 30 days, the beneficiary has not returned home and the providers can no longer deliver services as authorized on the Person-Centered Service Plan (PCSP) (e.g., the beneficiary has left the state and the return date is unknown), the DAASDHS RN will notify the DAAS LTSS Program Eligibility Specialist DHS Division of County Operations county office. Action will be taken by the DAAS LTSS Program Eligibility Specialist DHS Division of County Operations county office to close the waiver case.

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

212.500 Reporting Changes in Beneficiary’s Status 10-1-16

Because the provider has more frequent contact with the beneficiary, many times the provider becomes aware of changes in the beneficiary’s status sooner than the Division of Aging and Adult Services (DAAS) Registered Nurse (DAASDHS RN), or Case Manager, or DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist. It is the provider’s responsibility to report these changes immediately so proper action may be taken. Providers must complete the Waiver Provider Communication – Change of Participant Status Form (AAS-9511) and send it to the DAASDHS RN. A copy must be retained in the provider’s beneficiary case record. Regardless of whether the change may result in action by the DHS Division of County Operations county office, DAAS LTSS Program Eligibility Specialist, providers must immediately report all changes in the beneficiary’s status to the DAASDHS RN.

The Targeted Case Manager is responsible for monitoring the beneficiary’s status on a regular basis for changes in service need, referring the beneficiary for reassessment if necessary and
reporting any beneficiary complaints and changes in status to the DAASDHS RN, or DAASDHS RN Supervisor immediately upon learning of the change.

212.600 Relatives Providing ARChoices Services 1-1-16

All ARChoices services, except for Adult Family Homes, may be provided by a beneficiary’s relative, unless stated otherwise in this manual. No Adult Family Home provider, employee or family member of the provider may be related to the Adult Family Home waiver beneficiary.

For the purposes of this section, a relative or family member shall be defined as all persons related to the beneficiary by virtue of blood, marriage, or adoption.

The following is applicable for all waiver services:

A. Under no circumstances may Medicaid payment be made for any waiver service rendered by the waiver beneficiary’s:

1. Spouse
2. Legal guardian of the person
3. Attorney-in-fact granted authority to direct the beneficiary’s care

B. All providers, including relatives, are required to meet all ARChoices provider certification requirements, Arkansas Medicaid enrollment requirements and provide services according to the beneficiary’s PCSP and any established benefit limits for that specific service.

213.000 Description of Services

213.100 Adult Family Homes

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<tr>
<td>S5140</td>
<td>U1</td>
<td>Adult Family Homes Level A</td>
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Adult Family Homes services are personal care and supportive services (e.g., Attendant Care, transportation and medication oversight (to the extent permitted under State Law)), provided in a certified private home by a principal care provider who lives in the home.

Payment for Adult Family Home services is not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for Adult Family Home services does not include payments made, directly or indirectly, to members of the beneficiary’s immediate family.

Adult Family Home services provide a family living environment for adults who are functionally impaired and who, due to the severity of their functional Needs Intensitys, are considered to be at imminent risk of death or serious bodily harm and, as a consequence, are not capable of fully independent living.

The number of beneficiaries served by an Adult Family Home may not exceed three (3) and beneficiaries must be unrelated to the adult family home provider. “Unrelated” is defined as any person who is not related to the provider by virtue of blood, marriage, or adoption. Other than the Adult Family Home provider, immediate family members or caregivers residing in the adult family home with the waiver beneficiary are prohibited from receiving Medicaid reimbursement for direct provision of any ARChoices services.
Adult Family Home services shall be included in the Person-Centered Service Plan (PCSP) only when it is necessary to prevent the permanent institutionalization of a beneficiary as determined by the Division of Aging and Adult Services Registered Nurse (DAAS RN). The Adult Family Home provider is responsible for meeting the needs of the waiver beneficiary, as defined by this waiver service description, 24 hours/day, 7 days/week.

Adult Family Homes add a dimension of family living to the provision of supportive services and personal care services such as:

A. Bathing
B. Dressing
C. Grooming
D. Care for occasional incontinence (bowel/bladder)
E. Assistance with eating
F. Enhancement of skills and independence in daily living
G. Transportation to allow access to the community

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

Services must be provided according to the participant’s written ARChoices PCSP.

There are three (3) different reimbursement rates for Adult Family Homes based on the Level of Care required for the individual beneficiary. Level of Care is indicated by using a modifier with CPT Code S5140.

One (1) unit of service equals one (1) day. Adult Family Homes are 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 beneficiary.

For any given year of the ARChoices Waiver, Adult Family Homes shall charge waiver residents no more than 90.8% of the current Individual SSI Benefit amount rounded to the nearest dollar for room and board. For any given year of the ARChoices Waiver, ARChoices Waiver beneficiaries shall receive 9% of the current Individual SSI Benefit amount rounded to the nearest dollar for personal needs allowance.

The waiver eligible person will cover the cost of room and board in the Adult Family Home. In addition, the DAAS Long-Term Services and Supports (LTSS) Program Eligibility Specialist will determine individual liability for care services based on the waiver eligible person’s available resources. Medicaid will cover the remaining cost of waiver services provided to the waiver eligible person. The personal needs allowance is adequate to meet the other expenses of the waiver eligible person in the Adult Family Home and exceeds the personal needs allowance for beneficiaries in long term care facilities.

The Adult Family Home waiver beneficiary may receive up to 600 hours (2,400 units) of long-term facility-based respite per state fiscal year. The service of Adult Family Home is not allowed on the same date of service as respite service.

BENEFICIARIES RECEIVING ADULT FAMILY HOMES SERVICES ARE NOT ELIGIBLE TO RECEIVE ANY OTHER ARCHoICES SERVICE, EXCEPT FOR LONG-TERM FACILITY-BASED RESPITE.
Enrollment as an ARChoices Adult Family Homes provider requires certification by the Department of Human Services, Division of Aging and Adult Services (DAAS), as an Adult Family Home. Adult Family Homes providers must complete an application packet including Medicaid Provider forms; be tested over designated training materials and achieve a passing score and submit the home for inspection by designated DAAS staff. If substitute caregivers are identified, these beneficiaries must meet the same training and testing requirements as the Adult Family Homes provider. In addition, drug screens and background checks are required for the provider, substitute caregivers and provider family members residing in the home and who are over the age of sixteen (16). Providers must recertify with DAAS annually. This requires submission of a renewal application packet and home inspection, as well as documentation of at least twelve hours of related training activities.

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

As a condition of certification, each Adult Family Homes provider shall execute with and provide to each beneficiary an admission agreement specifying services to be provided, the beneficiary’s cost for room and board, conditions and rules governing the beneficiary and grounds for termination of residency. Each Adult Family Homes provider will also be required to develop and maintain written program policies. Program policies must include and comply with the HCBS Settings rules found in section C of 201.105.

NOTE: The Adult Family Home provider’s ElderChoices certification will be valid as an ARChoices Adult Family Home provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

NOTE: At the next annual certification, the Adult Family Home provider must have policies in place that include and comply with the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

### 213.210 Attendant Care Services 10-1-16

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<td>S5125</td>
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<td>Attendant Care Services</td>
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<td>S5125</td>
<td>U2</td>
<td>Attendant Care Self-Directed Model</td>
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Attendant Care services are designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening or restoring an eligible beneficiary’s functioning in his or her own home or elsewhere in the community where the beneficiary engages in activities, including work-related activities. Attendant Care services may be provided in a beneficiary’s home or while accompanying the beneficiary to other locations, including without limitation for medical appointments or community activities, subject to the restrictions on travel time in section 213.220.

Attendant Care services consists of assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks through hands-on assistance, supervision and/or cueing.

Hands-on assistance, supervision and/or cueing are defined as:

A. "Hands-on assistance" means a provider physically performs all or part of an activity because the individual is unable to do so.

B. "Set-up", a form of hands on assistance, means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.
C. “Supervision” means a provider must be near the individual to observe how the individual is completing a task.

D. “Cueing and/or reassurance” means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.

E. "Monitoring", a form of supervision, means a provider must observe the individual to determine if intervention is needed.

F. “Stand-by”, a form of supervision, means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

G. "Support", a form of supervision, means to enhance the environment to enable the individual to be as independent as possible.

H. The following forms of assistance combine elements of Hands-on assistance, supervision and/or cueing:

I. "Redirection", a form of supervision or cueing, means to divert the individual to another more appropriate activity.

J. “Memory care support”, a blend of supervision, cueing and hands-on assistance. Includes services related to observing behaviors, supervision and intervening as appropriate in order to safeguard the service beneficiary against injury, hazard or accident. These specific supports are designed to support beneficiaries with cognitive impairments.

Activities of daily living include:

A. Eating

B. Bathing

C. Dressing

D. Personal hygiene (grooming, shampooing, shaving, skin care, oral care, brushing or combing of hair, and menstrual hygiene, etc.)

E. Toileting

F. Mobility/ambulating, including functional mobility (moving from seated to standing, getting in and out of bed) and mastering the use of adaptive aids and equipment

Instrumental activities of daily living include:

A. Meal planning and preparation of meals consumed only by the participant

B. Managing finances

C. Laundry for the participant or incidental to the participant’s care

D. Shopping and errands for food, clothing, and other essential items required specifically for the health and maintenance of the participant;

E. Communication

F. Traveling

D. Housekeeping (cleaning of furniture, floors, and areas directly used by the participant)

H. E. Assistance with medications (to the extent permitted by nursing scope of practice laws)
Health-related tasks are limited to the following activities:

A. Performing and recording simple measurements of body weight, blood glucose, heart pulse, blood pressure, temperature (forehead, tympanic, or oral), respiratory rate, and blood oxygen saturation, if in physician’s order or medical plan of care. Attendant must use an appropriate weight scale and FDA-approved, hand-held personal health monitoring device(s);

B. Additional assistance with self-administration of prescribed medications; and/or

C. Emptying and replacing colostomy and ostomy bags.

Health-related tasks must be:

A. Consistent with all applicable State scope of practice laws and regulations;

B. Within the documented skills, training, experience, and other relevant competencies of the attendant performing the task;

C. For the care and safety of the participant, do not require monitoring or supervision of the attendant by a licensed physician, nurse, or therapist;

D. Necessary to meet specific needs of the participant consistent with a written plan of care by a physician or registered nurse;

E. Tasks that the participant is unable to perform for themselves without hands-on assistance, direct supervision, and/or active cueing of the attendant.

The provision of assistance with ADLs, IADLs, or health-related tasks does not entail nursing care.

Attendant care services tasks must be:

A. Reasonable and medically necessary, supported by the individual’s latest independent assessment, and consistent with the individual’s Level of Care;

B. Not available from another source (including without limitation family members, a member of the participant’s household, or other unpaid caregivers; a Medicaid State Plan covered service; the Medicare program; the participant’s Medicare Advantage plan or Medicare prescription drug plan; or private long-term care, disability, or supplemental insurance coverage);

C. Expressly authorized in the individual’s person-centered service plan;

D. Not in excess of or otherwise inconsistent with limits on the amount, frequency, or duration of services;

E. Provided by qualified, Medicaid-certified providers and in compliance with all applicable Arkansas Medicaid program regulations and provider manuals; and

F. Provided in compliance with all applicable Arkansas scope of practice laws and regulations pertaining to nurses, physicians, skilled therapists, and other professionals.

Attendant care services exclude all of the following:

A. Medical, skilled nursing, pharmacy, skilled therapy services, medical social services, or medical technician services of any kind, including without limitation: aseptic or sterile procedures; application of dressings; medication administration; injections, observation and
assessment of health conditions, other than as permitted for health-related tasks above;
insertion, removal, or irrigation of catheters; tube or other enteral feedings; tracheostomy
care; oxygen administration; ventilator care; drawing blood; and care and maintenance of
any medical equipment;

B. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists,
or aestheticians, except for necessary assistance with personal hygiene and basic grooming;

C. Services provided for any person other than the participant, including without limitation a
provider, family member, household resident, or neighbor;

D. Companion, socialization, entertainment, or recreational services or activities of any kind
(including without limitation game playing, television watching, arts and crafts, hobbies, and
other activities pursued for pleasure, relaxation, or fellowship);

E. Cleaning of any spaces of a home or place of residence (including without limitation kitchen,
bathroom, living room, dining room, family room, and utility or storage rooms, and the floors,
furnishings, and appliances therein) shared by the participant with one or more adults who
are, together or separately, physically able to perform housekeeping of these areas; and

F. Habilitation services, including assistance in acquiring, retaining, or improving self-help,
socialization, and/or adaptive skills.

Participants may choose to receive authorized attendant care services through any of the following:

A. Home health agency licensed as Class A by the Arkansas State Board of Health, certified
by DPSQA, and enrolled as a Medicaid provider;

B. Home health agency licensed as Class B by the Arkansas State Board of Health, certified
by DPSQA, and enrolled as a Medicaid provider;

C. Private care agency licensed by the Arkansas State Board of Health, certified by DPSQA,
and enrolled as a Medicaid provider; or

D. Consumer-directed attendant care through IndependentChoices, the Arkansas self-directed
personal assistance benefit under section 1915(j) of the Social Security Act, provided the
individual is capable of self-directing the assistance and subject to the requirements of the
IndependentChoices provider manual and applicable provider qualifications and certification.

The aggregate amount, frequency, and duration of attendant care services must be consistent with
the aggregate amounts, frequencies, and durations calculated by DHS for the beneficiary in
accordance with the Arkansas Medicaid Task and Hour Standards ("THS"), as issued by DAABHS
and posted publicly on the DHS website with the ARChoices waiver provider manual. DAABHS will
publish and periodically update the THS as necessary, following a public notice and comment
process. The THS specifies limits on each ADL, IADL, and health-related task at the intensity of
human assistance needed for the task, including maximum frequency (by day or week or month),
maximum minutes per task allowable, and maximum hours by day, week, month, and year. Any
aggregate amounts, frequencies, or durations in excess of the weekly or monthly limits calculated by
DHS for the beneficiary in accordance with the THS are not covered.

Attendant care services are not available (not covered and not reimbursable) through the ARChoices
program when and to the extent any of the following may apply:

A. When reasonably comparable or substitute services are available to the individual through
an Arkansas Medicaid State Plan benefit including without limitation personal care services,
home health services, and private duty nursing services;
B. When assistance with the equivalent ADL, IADL, or health-related task(s) is covered under an Arkansas Medicaid State Plan benefit but determined as medically unnecessary for the individual during adjudication of a prior authorization request or utilization review;

C. When assistance with the comparable ADL, IADL, or health-related task(s) is available through targeted or supplemental benefits offered by the participant’s Medicare Advantage plan;

D. When attendant care services delivered through a home health agency or private care agency are provided by the waiver beneficiary’s (i) spouse; (ii) legal guardian of the person; or (iii) attorney-in-fact granted authority to direct the beneficiary’s care;

E. On dates of service when the participant:
   1. Receives Medicare home health aide services, whether through traditional Medicare fee-for-service or a Medicare Advantage plan of any kind for the same tasks;
   2. Receives targeted or other supplemental benefits from a Medicare Advantage plan of any kind, where such supplemental services are reasonably comparable to or duplicative of attendant care services, personal care services, or self-directed personal assistance;
   3. Spends more than five hours at an adult day services or adult day health services facility, unless prior approved in writing by the DHS RN;
   4. Receives long-term or short-term facility-based respite care; and/or
   5. Receives services from an inpatient hospital, nursing facility, assisted living facility, hospice facility, or residential care facility, unless approved in writing by a DHS RN as reasonable and necessary given the time of day of the facility admission or discharge, the need for transition assistance, or an inpatient hospital admission incident to an emergency department visit or direct inpatient admission by the attending physician;

F. When a duplicate claim for the same performance of the same task is paid or submitted for personal care services, self-directed personal assistance, or home health aide services under the Medicaid State Plan; and/or

G. For a task that was not actually performed.

Beneficiaries may choose to self-direct this service through Arkansas's IndependentChoices program under 1915(j) authority; or may receive services through an agency. The IndependentChoices Medicaid Provider Manual describes the self-directed service delivery model.

Attendant Care services must be provided according to the beneficiary ARChoices written PCSP.

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

Benefit limits will be determined on a client basis based on application of the Arkansas Medicaid Task and Hour Standards (THS) and the service limitations described in this manual. The assessed level of need by the DAAS RN. The highest RUG level allows a maximum allocation of 324 units (81 hours) per week, 1,436 units (359 hours) per month, or 16,848 units (4,212 hours) per year.
DAABHS will update the Person-Centered Service Plan to take into account any changes in the participant’s condition and/or living arrangements that would affect the number of hours of attendant care that could be approved under the Task and Hour Standards.

Fifteen (15) minutes of service equals one (1) unit.

An ARChoices beneficiary who spends more than five (5) hours (20 units) at an adult day services or adult day health services facility or who is receiving short-term, facility-based respite care will not be eligible for Attendant Care services on the same date of service unless authorized by the DAASDHS RN.

An ARChoices beneficiary receiving long-term, facility-based respite care is not eligible for Attendant Care services on the same date of service.

213.220 Travel Time of Attendant Accompanying Participant 1-1-19

A. The Attendant Care benefit only covers attendant travel time when all of the following apply:

1. The attendant accompanies the participant in the same vehicle as the participant travels to and returns from a community location for medical appointment or community activity;

2. The travel time billed is solely for necessary time in transit from the participant’s home to the community location and the return travel from the community location to the participant’s home;

3. The participant’s participation in the local community activity is for the benefit of the participant and to meet the participant’s goals for independent living in the community, and the travel, including stops, is not for the benefit or convenience of any other person (including the attendant, a family member, the driver, or other passengers);

4. The traveling activity itself is for practical transit within the community and not for diversional or recreational purposes of any kind;

5. The participant’s approved patient-centered service plan includes Attendant Care service hours for one or both of the following activities of daily living (ADLs): toileting and mobility / ambulating;

6. While in transit to and from the community location, the participant requires, or is likely to need given assessed functional limitations, hands-on assistance with the ADL task of toileting or the ADL task of mobility / ambulating; and

7. The travel time is reasonable given driving distances, traffic conditions, and weather, with time and locations documented;

B. Travel time is not reimbursable if any other adult person accompanying (or driving) the participant is a family member and is reasonably able to assist the participant in transit if needed.

C. Travel time accompanying a participant will count against the total number of Attendant Care hours per month authorized in the participant’s person-centered service plan.

D. Requesting Hours for Travel Time of Attendant Accompanying Participant:

Participants vary in their medical appointments, participation in community activities, the availability of family or other assistance they may need while traveling, and the time involved when traveling to medical appointments and local community activities. When covered, travel time of an attendant accompanying a participant is incident to but itself not the ADL task of toileting or the ADL task of mobility / ambulating. Therefore, the Task and Hour Standards are not currently used to help determine the number of Attendant Care hours, if
any, associated solely with travel time of an attendant accompanying a participant to a medical visit or community activity. During the home visit to discuss the person-centered service plan, the participant (or their legal representative) should inform the DHS nurse of the individual’s community activities, need for an attendant to accompany them, and the distances and roundtrip travel times typically involved. Based on this information, consistent with the above requirements, and within the person’s applicable Individual Services Budget, the DHS nurse may increase the number of Attendant Care hours per month covered in the PCSP to reasonably accommodate the travel time of an attendant accompanying the participant.

213.230 Attendant Care Services Certification Requirements 1-1-18

The following requirements must be met prior to certification by the Division of Provider Services and Quality Assurance (DPSQA) Aging and Adult Services (DAAS) by providers of attendant care services. The provider must:

A. Hold a current Arkansas State Board of Health Class A and/or Class B license, or Private Care Agency license.

B. All owners, principals, employees, and contract staff of an attendant care services provider must have comply with national and state criminal background checks and central registry checks. Criminal background and central registry checks must comply with according to Arkansas State Law at Code Annotated §§ 20-33-213 and 20-38-101 et seq. Criminal background checks shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

C. Employ and supervise direct care staff who:

1. Prior to providing an ARChoices service, have received instruction regarding the general needs of the elderly and adults with physical disabilities;
2. Possess the necessary skills to perform the specific services required to meet the needs of the beneficiary the direct care staff member is to serve; and
3. Are placed under bond by the provider or are covered by the professional medical liability insurance of the provider.

Each provider must maintain adequate documentation to support that direct care staff meets the training and, as applicable, testing requirements according to licensure, agency policy and DAAS/DPSQA certification.

Attendant Care service providers who hold a current Arkansas State Board of Health Class A and/or Class B license or Private Care Agency license must recertify with DPSQA annually every three years; however, the provider must submit a copy the agency’s current license to DAAS each year when the license is renewed.

Providers are required to submit copy of renewed license to DPSQADAAS.

NOTE: The Class A, Class B or Private Care Agency license provider’s ElderChoices and AAPD certification will be valid as an Attendant Care services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices and AAPD.

213.240 Environmental Accessibility Adaptations/Adaptive Equipment 10-1-16
Environmental Accessibility Adaptations/Adaptive Equipment services enable the individual to increase, maintain and/or improve his or her functional capacity to perform daily life tasks that would not be possible otherwise. Environmental Accessibility Adaptations/Adaptive Equipment is physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, to function with greater independence in the home and preclude or postpone institutionalization. Adaptive equipment also enables the ARChoices beneficiary to increase, maintain and/or improve his/her functional capacity to perform daily life tasks that would not be possible otherwise and perceive, control or communicate with the environment in which he or she lives.

Excluded are adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, air conditioning and others. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be in accordance with applicable state or local building codes. All dwellings that receive adaptations must be in good repair and have the appearance of sound structure.

Permanent fixtures are not allowed on rented or leased properties.

Reimbursement is not permitted for Environmental Accessibility Adaptations/Adaptive Equipment services provided by a waiver beneficiary’s:

1. Spouse;
2. Legal guardian of the person; or
3. Attorney-in-fact granted authority to direct the beneficiary’s care.

### 213.280 Provider Qualifications Environmental Accessibility Adaptations/Adaptive Equipment

Individuals or businesses seeking certification by the Division of Provider Services and Quality Assurance (DPSQA) Aging and Adult Services (DAAS) and enrollment as Medicaid providers of environmental accessibility adaptations/adaptive equipment services must meet the following criteria:

A. The provider of services must be a builder, tradesman or contractor.

B. The provider must be licensed (where applicable) as appropriate for home improvement contracting or adaptation and equipment provided.

C. The provider must certify that his or her work meets state and local building codes.

D. The provider must obtain all applicable permits.

E. The provider must be knowledgeable of and comply with the Americans with Disabilities Act Accessibility Guidelines.

F. Contractors are required to adhere to the Uniform Federal Accessibility Standards.

**NOTE:** All environmental modifications requiring electrical or plumbing work must be completed by an appropriately licensed professional. If the proposed work requires a plumbing or electrical license, the contractor must submit a copy of the contractor’s plumbing or electrical license with the claim form.
If a contractor subcontracts with an electrician or plumber, the contractor must submit a copy of the subcontractor's license with the claim form.

213.290 Environmental Modifications/Adaptive Equipment

Prior to payment for this service, the waiver beneficiary is required to secure 3 separate itemized bids for the same service. Each bid must itemize the work to be done and must specifically identify any work that requires a plumbing or electrical license. The bids are reviewed by the Division of Aging and Adult Services (DAAS) Division of Aging, Adult, and Behavioral Health Services (DHSDAAS RN) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided. All modification funds must be verified by DAABHS the DAAS Provider Certification Unit prior to receiving services.

Each claim must be signed by the provider, the waiver beneficiary and DAASDHS RN, or designee. A statement of satisfaction form must be signed by the waiver beneficiary prior to any claim being submitted. All claim forms, bids and client satisfaction statement forms must be submitted to DAABHS the DAAS Provider Certification Unit prior to submission for payment.

NOTE: The Environmental Modification provider's Alternatives for Adults with Physical Disabilities (AAPD) certification will be valid as an ARChoices Environmental Modification provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under AAPD.

213.310 Hot Home-Delivered Meals

Hot Home-Delivered Meals provide one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with the DAASDAABHS Nutrition Services Program Policy Number 206.

Hot Home-Delivered Meal services provide one daily nutritious meal to eligible beneficiaries who are homebound. Homebound is defined as a person with normal inability to leave home without assistance (physical or mental) from another person; a person who is frail, homebound by reason of illness or incapacitating disability or otherwise isolated; or for whom leaving home requires considerable and taxing effort by the individual and absences from the home are infrequent, relatively short in duration or are attributable to the need to receive medical treatment.

Additionally, the beneficiary must:

A. Be unable to prepare some or all of his or her own meals;
B. Have no other individual to prepare his or her own meals; and
C. Have the provision of the Home-Delivered Meals included on his or her PCSP

The provision of a Home-Delivered Meal is the most cost-effective method of ensuring a nutritiously adequate meal.

The Home-Delivered Meals provider must maintain a log sheet signed by the beneficiary that includes date and time of delivery each time a meal is delivered to document receipt of the meal.

Hot Home-Delivered Meals must be provided according to the beneficiary’s written ARChoices PCSP.
### Procedure Code | Required Modifier | Description
--- | --- | ---
S5170 | U2 | Hot Home-Delivered Meal
S5170 | — | Frozen Home-Delivered Meal
S5170 | U1 | Emergency Home-Delivered Meal

## 213.311  Hot Home-Delivered Meal Provider Certification Requirements 1-1-18

To be certified by the Division of Aging and Adult Services (DAAS) and Division of Provider Services and Quality Assurance (DPSQA) as a provider of Hot Home-Delivered Meal services, a provider must:

A. Be a nutrition services provider whose kitchen is approved by the Department of Health, and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAASDAABHS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

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

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

*NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states’ applicable laws and regulations.

E. All owners, principals, employees, and contract staff of a hot, home-delivered meal services provider must comply with national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with according to Arkansas State Law at Code Annotated §§ 20-33-213 and 20-38-101 et seq. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.

F. Notify the DAASDHS RN immediately if:

1. There is a problem with delivery of service
2. The beneficiary is not consuming the meals
3. A change in the individual’s condition is noted

**NOTE:** Changes in service delivery must receive prior approval by the DAASDHS RN who is responsible for the individual’s Person-Centered Service Plan (PCSP). Requests must be submitted in writing to the DAASDHS RN. Any changes in the individual’s circumstances must be reported to the DAASDHS RN via form AAS-9511.
Home-Delivered Meals, hot or frozen, shall be included in the beneficiary’s PCSP only when they are necessary to prevent the institutionalization of an individual.

Hot Home-Delivered Meals providers must recertify with DAAS every three years; however, DAAS must maintain DPSQA annually, and the provider shall attach a copy of the agency’s current Food Establishment Permit at all times to the annual recertification.

**NOTE:** The Home-Delivered Meals provider’s ElderChoices certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

**213.320 Frozen Home-Delivered Meals 1-1-16**

Frozen Home-Delivered Meals service provides one meal per day with a nutritional content equal to 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences. The meals must comply with the Dietary Guidelines for Americans and with DAASDAABHS Nutrition Services Program Policy Number 206.

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

A. Reside in remote areas where daily hot meals are not available;
B. Choose to receive a frozen meal rather than a hot meal; or
C. Are at nutritional risk and are certified to receive a meal for use on weekends or holidays when the hot meal provider is not in operation.

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

It is the certified provider’s responsibility to deliver the meals regardless if they are hot or frozen. Meals may not be left on the doorstep. The meals cannot be mailed to the individual via United States Postal Service or delivered by paid carrier such as Fed Ex or UPS.

**213.321 Beneficiary Requirements for Frozen Home-Delivered Meals 1-1-16**

The beneficiary must:

A. Be homebound, which is defined by the following requirements:
   1. The person is normally unable to leave home without assistance (physical or mental) from another person;
   2. The person is frail, homebound by reason of illness or incapacitating disability or otherwise isolated;
   3. Leaving home requires considerable and taxing effort by the individual; and
   4. 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 DAASDAABHS.

E. Have the provision of frozen meals included on his or her PCSP as developed by the appropriate DAASDHS RN.

Frozen Home-Delivered Meals must be documented on the ARChoices PCSP by the DAASDHS RN and must be provided in accordance with the beneficiary’s written ARChoices PCSP.

213.323 Frozen Home-Delivered Meal Provider Certification Requirements 1-1-18

In order to become approved providers of frozen meals, providers must meet all applicable requirements of the Aging and Adult Services (DAAS) DAABHS Nutrition Services Program Policy Number 206.

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

A. Be a nutrition services provider whose kitchen is approved by the Department of Health, and whose meals are approved by a Registered Dietitian who has verified by nutrient analysis that meals provide 33 1/3 percent of the Dietary Reference Intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and DAASDAABHS Nutrition Services Program Policy Number 206.*

B. Comply with all federal, state, county and local laws and regulations concerning the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, handling, service, delivery and transportation of meals;*

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

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

*NOTE: For providers located in Arkansas, all requirements must meet applicable Arkansas laws and regulations. For Home-Delivered Meal providers located in bordering states, all requirements must meet their states’ applicable laws and regulations.

E. All owners, principals, employees, and contract staff of a home-delivered meal services provider must have complied with national and state criminal background checks and central registry checks. Criminal background checks and central registry checks must comply with according to comply with criminal background checks according to Arkansas Code Annotated §§ State Law at 20-33-213 and 20-38-101 et seq. Criminal background shall be repeated at least once every five years. Central registry checks shall include the Child Maltreatment Central Registry; the Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and the Certified Nursing Assistant/Employment Clearance Registry.
F. Provide frozen meals that:

1. Were prepared or purchased according to the Department of Health and \textit{DAAS DAABHS} Nutrition Services Program Policy guidelines in freezer-safe containers that can be reheated in the oven or microwave.

2. Are kept frozen from the time of preparation through placement in the individual’s freezer.

3. Have a remaining freezer life of at least three months from the date of delivery to the home.

4. Are part of a meal cycle of at least four weeks (i.e., four weeks of menus that differ).

5. Are properly labeled, listing food items included and non-frozen items that are delivered with the frozen components to complete the meal (which must include powdered or fluid milk, whichever is preferred by the ARChoices beneficiary), menu analysis as required by \textit{DAABHS DAAS} Nutrition Services Program Policy if other than \textit{DAABHS DAAS} menus are used and both packaging and expiration dates.

\textbf{NOTE:} The milk must be delivered to the beneficiary at least seven (7) days prior to its expiration date.

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

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

1. Are prepared and packaged only in a central kitchen or on-site preparation kitchen;

2. Are prepared specifically to be frozen;

3. Are frozen as quickly as possible;

4. Are cooled to a temperature of below 40 degrees Fahrenheit within four hours;

5. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process, with temperatures recorded and kept on file for audit;

6. Are packaged in individual trays, properly sealed and labeled with the date, contents and instructions for storage and reheating;

7. Are frozen in a manner that allows air circulation around each individual tray;

8. Are kept frozen throughout storage, transport and delivery to the beneficiary; and

9. Are discarded after 30 days.

H. I. Verify quarterly that all beneficiaries receiving Frozen Home-Delivered Meals continue to have the capacity to store and heat meals and are physically and mentally capable of performing simple associated tasks unless other appropriate arrangements have been made and approved by \textit{DAAS DAABHS}. Any changes in the individual’s circumstances must be reported to the \textit{DAAS DAABHS} RN via form AAS-9511.

I. J. Notify the appropriate \textit{DAAS DAABHS} RN immediately if:

1. There is a problem with delivery of service

2. The individual is not consuming the meals

3. A change in an individual’s condition is noted

\textbf{NOTE:} Changes in service delivery must receive prior approval by the \textit{DAAS DAABHS} RN who is responsible for the individual’s Person-Centered Services Plan
(PCSP). Requests must be submitted in writing to the DAASDHS RN. Any changes in the individual’s circumstances must be reported to the DAASDHS RN via form AAS-9511.

K. Contact each individual daily Monday through Friday, either in person or by phone, to ensure the individual’s safety and well-being. This is not required for:

1. Individuals receiving Frozen Home-Delivered Meals only for weekends; or
2. Individuals who receive Attendant Care services or Personal Care services at least three (3) times per week.

Home-Delivered Meals, hot or frozen, shall be included in the beneficiary’s PCSP only when they are necessary to prevent the institutionalization of an individual.

Frozen Home-Delivered Meals providers must recertify with DPSQA annually DAAS every three years; however, DAASDPSQA must maintain a copy of the agency’s current Food Establishment Permit at all times.

NOTE: The Home-Delivered Meals ElderChoices provider’s certification will be valid as an ARChoices Home-Delivered Meals provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.330 Limitations on Home-Delivered Meals (HDMs) 10-1-16

One unit of service equals one meal. The maximum number of HDMs eligible for Medicaid reimbursement per month equals 31 meals. This includes hot, frozen or a combination of the two. There is no separate benefit limit for frozen meals.

The maximum number of emergency meals per State Fiscal Year is four (4).

Frozen HDMs may be provided daily to eligible beneficiaries. A maximum of seven (7) meals may be delivered at one time.

HDM providers may deliver more than seven meals at one time, if:

A. The waiver beneficiary receives Attendant Care services or Personal Care services at least three (3) times per week,
B. Frozen HDMs are ordered on the Person-Centered Services Plan (PCSP),

C. The waiver beneficiary has the means of storing 14 frozen meals (as verified by the DAASDHS RN).

HDM providers delivering frozen meals may deliver 14 at one time if the DAASDHS RN enters 14 meals delivery approved in the comments section of the HDM entry on the PCSP. If this statement is not on the PCSP, or if any of the other factors above are not in place, the meal providers cannot deliver more than seven (7) meals at one time.

An ARChoices beneficiary may not be provided with a Hot or Frozen HDM on any day during which the individual receives more than five (5) hours of in-home or facility-based Respite care or more than five (5) hours of Adult Day Services or Adult Day Health Services. (Licensure mandates that providers of these services provide a meal or meals; therefore, a HDM on these dates is a duplicative service and prohibited under waiver guidelines.)

NOTE: Medicaid reimbursement for HDMs is not allowed on the same day to beneficiaries who are also attending Adult Day Services, Adult Day Health Services, or facility-based Respite care for more than five (5) hours. When applying this policy, the time of day the beneficiary receives day services or
respite services are also a factor. Whether there is duplication of services will be determined by comparing the time of day during which services occur.

When considering whether a HDM is billable for an individual receiving Adult Day Services, Adult Day Health Services or facility-based Respite services, on a specific date of service, the following must be applied:

If an ARChoices beneficiary is receiving Adult Day Services, Adult Day Health Services or facility-based Respite at any time 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 timeframe, the noon meal must also be served to this individual. A HDM is not allowable on the same date of service. This is true regardless of the total number of Adult Day Services, Adult Day Health Services or Respite hours provided.

213.340 Combination of Hot and Frozen Home-Delivered Meals 1-1-16

In instances where the ARChoices beneficiary wishes to receive a combination of hot and frozen meals, the DAASDHS RN shall evaluate the beneficiary’s situation based on the criteria set forth in Section 213.320, Frozen Home-Delivered Meals. If the criteria are met, the DAASDHS RN may prescribe on the PCSP a combination of hot and frozen meals to be delivered.

213.350 Emergency Meals 10-1-16

Beneficiaries may receive up to four (4) emergency meals per state fiscal year. The meals must:

A. Contain 33 1/3 percent of the Dietary Reference intakes established by the Food and Nutrition Board of the National Academy of Sciences and comply with the Dietary Guidelines for Americans and Division of Aging and Adult Services (DAAS) (DAABHSDAAS) Nutrition Services Program Policy Number 206.

B. Be labeled “Emergency Meal” in large print, with instruction on use of the meal.

C. Be used within the limits of their shelf life, usually within six months.

213.400 Personal Emergency Response System 1-1-16

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<tr>
<th>Procedure Code</th>
<th>Required Modifier</th>
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<tr>
<td>S5161</td>
<td>UA</td>
<td>PERS Unit</td>
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<tr>
<td>S5160</td>
<td>—</td>
<td>PERS Installation</td>
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</tbody>
</table>

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 beneficiaries 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 DAASDHS RN must verify that the individual is capable, both physically and mentally, of operating the PERS unit.

PERS must be included in the beneficiary’s written ARChoices PCSP.

PERS providers must contact each beneficiary 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 beneficiary 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 beneficiary’s record. See Section 214.000 for other documentation requirements.

One (1) unit of service equals one (1) day month. PERS is limited to a maximum of thirty-one (31) units per month twelve (12) units per year.

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 ARChoices beneficiaries who are accessing PERS services for their first time or for the current period of re-eligibility for ARChoices Waiver Services. In the event of extenuating circumstances that result in the need for reinstallation, the provider may contact the Division of Aging, Adult, and Behavioral Health Services of Aging and Adult Services for extension of the benefit.

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

213.410 Personal Emergency Response System (PERS) Certification

To be certified by Division of Provider Services and Quality Assurance (DPSQA) Aging and Adult Services (DAAS) as a provider of personal emergency response services, a provider must:

A. Provide, install and maintain Federal Communications Commission (FCC) approved equipment which meets all Underwriter Laboratories Safety Standards;

B. Designate or operate an emergency response center to receive signals and respond according to specified operating protocol;

C. Establish a response system for each beneficiary and ensure responders receive necessary instruction and training; and

D. Ensure that equipment is installed by qualified providers who also provide instruction and training to beneficiaries.

PERS providers must recertify annually with DPSQADAAS.

NOTE: The PERS ElderChoices provider’s certification will be valid as an ARChoices PERS provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.500 Adult Day Services

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<tr>
<th>Procedure Code</th>
<th>Required Modifier</th>
<th>Description</th>
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<tr>
<td>S5100</td>
<td>U1</td>
<td>Adult Day Services, 8-20 Units Per Date of Service</td>
</tr>
<tr>
<td>S5100</td>
<td>—</td>
<td>Adult Day Services, 21-40 Units Per Date of Service</td>
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</tbody>
</table>

Adult day services facilities are licensed by the Office of Long Term Care (OLTC) Division of Provider Services and Quality Assurance (DPSQA) 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 beneficiaries’ own homes.
When provided according to the beneficiary’s written ARChoices Person-Centered Service Plan (PCSP), ARChoices beneficiaries may receive adult day services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day, according to the beneficiary’s written PCSP. Adult day services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month. One (1) unit of service equals 15 minutes.

As required, beneficiaries who are present in the facility for more than 20 units (5 hours) a day (procedure code S5100) must be served a nutritious meal that equals one-third of the Recommended Daily Allowance. Therefore, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than 20 units (5 hours) of adult day services. Additionally, beneficiaries who attend an adult day service for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the Division of Aging and Adult Services Registered Nurse (DAASDHS 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 services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services, day health services 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 DAASDHS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.

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

If an ARChoices beneficiary is receiving day services, day health services 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 services or respite units provided.

Adult day services and day health services providers are required to maintain a daily attendance log of beneficiaries. Section 214.000 contains information regarding additional documentation requirements.

**213.510 Adult Day Services Certification Requirements**

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) Aging and Adult Services (DAAS) as a provider of adult day services in Arkansas, a provider must be a person, corporation, partnership, association or organization licensed by the Arkansas Department of Human Services, Office of Long-Term Care Division of Provider Services and Quality Assurance 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.

In order to be certified by DAASDPSQA, Adult Day Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Services providers must recertify with DAAS every three years DPSQA annually; however, DAAS DPSQA must maintain a copy of the agency’s current Adult Day Care license at all times.

In order to be recertified by DPSQADAAS, Adult Day Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DPSQADAAS.
NOTE: The Adult Day Services ElderChoices provider’s certification will be valid as an ARChoices Adult Day Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

### 213.600 Adult Day Health Services (ADHS) 10-1-16

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<th>Procedure Code</th>
<th>Required Modifier</th>
<th>Description</th>
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<tr>
<td>S5100 TD, U1</td>
<td>Adult Day Health Services, 8-20 Units Per Date of Service</td>
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<tr>
<td>S5100 TD</td>
<td>Adult Day Health Services, 21-40 Units Per Date of Service</td>
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Adult day health services facilities are licensed to provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, social services and activities to beneficiaries who are functionally impaired and who, due to the severity of their functional impairment, are not capable of fully independent living.

Adult day health services programs provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary that cannot be provided by adult day care programs. Adult day health services are appropriate only for beneficiaries 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

ARChoices beneficiaries may receive adult day health services for 8 or more units (2 or more hours) per day, not to exceed 40 units (10 hours) per day when the service is provided according to the beneficiary’s written ARChoices Person-Centered Service Plan (PCSP). Adult day health services of less than 8 units (2 hours) per day are not reimbursable by Medicaid. Adult day health services may be utilized up to 200 units (50 hours) per week, not to exceed 920 units (230 hours) per month.

Beneficiaries who are present in the facility for more than 20 units (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, ARChoices beneficiaries are not eligible to receive a home-delivered meal on the same day they receive more than five (5) hours of adult day health services. Additionally, beneficiaries who attend an adult day health services for more than 20 units (5 hours) are not eligible to receive Attendant Care services on the same date of service unless authorized by the Division of Aging and Adult Services (DAAS (DHSDAAS RN).

Adult day health services providers are required by licensure to maintain a daily attendance log of beneficiaries. 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 services, adult day health services, or facility-based respite care for more than 20 units (5 hours). The time of day the beneficiary is receiving day services 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 DAASDHS RN and/or Department of Human Services (DHS) audit staff and considered when determining any duplication in services for beneficiaries participating in the ARChoices Program.
Providers must consider the following to determine whether a home-delivered meal is billable for an individual receiving day services or facility-based respite services on a specific date of service.

If an ARChoices beneficiary is receiving day services 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 services or respite units provided.

213.610 Adult Day Health Services (ADHS) Provider Certification Requirements

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

In order to be certified by DAASDPSQA, Adult Day Health Services providers must meet the Home and Community-Based Services (HCBS) Settings rules found in section C of 201.105.

Adult Day Health Services providers must recertify with DAAS every three years DPSQA annually; however, DAASDPSQA must maintain a copy of the agency’s current Adult Day Health Care license at all times. In order to be recertified, Adult Day Health Services providers must meet the HCBS Settings rules found in section C of 201.105.

Providers are required to submit copy of renewed license to DAASDAABHS.

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

NOTE: The Adult Day Health Services ElderChoices provider’s certification will be valid as an ARChoices Adult Day Health Services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.620 Prevocational Services

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<td>Prevocational Services Skills Development</td>
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<tr>
<td>T2015 U3</td>
<td></td>
<td>Prevocational Services Career Exploration</td>
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Prevocational services are available to ARChoices waiver participants with physical disabilities who wish to join the general workforce. Prevocational Services comprise a range of learning and experiential type activities that prepare a participant for paid employment or self-employment in the community.

Prevocational services are as follows:

1. Development and teaching of general employability skills (non-job-task-specific strengths and skills) directly relevant to the participant’s pre-employment needs and successful participation in individual paid employment. These skills are: ability to communicate
effectively with supervisors, coworkers, and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; and skills related to obtaining paid employment. Excluded are services involving development or training of job-specific or job-task oriented skills.

2. Career exploration activities designed to develop an individual career plan and facilitate the participant’s experientially-based informed choice regarding the goal of individual paid employment. These may include business tours, informational interviews, job shadows, benefits education and financial literacy, assistive technology assessment, and local job exploration events. The expected outcome of career exploration activities is a written, actionable, person-centered career plan designed to lead to community employment or self-employment for the participant.

The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the participant interacts with individuals without disabilities, other than those providing services to the participant or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Prevocational services may be provided one-to-one or in a small group format and may be provided as a site-based service or in a community setting, consistent with requirements of the ARChoices provider manual.

All prevocational services must be prior approved in the participant’s person-centered service plan, provided through a DPSQA-certified prevocational services provider, and delivered and documented consistent with requirements of the ARChoices provider manual.

Prevocational services exclude any services otherwise available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 (Rehab Act), the Individuals with Disabilities Education Act (IDEA), or any other federally funded (non-Medicaid) source. Proper documentation shall be maintained in the file of each individual receiving prevocational services under the waiver.

The amount of all prevocational services provided to any participant shall not exceed $2,500 per lifetime.

The amount of career exploration activities provided per participant shall not exceed 30 hours.

The duration of prevocational services provided to any given participant shall be limited to 180 days (six months). Services not completed within this timeframe are not covered.

Fifteen (15) minutes of service equals one (1) unit.

Providers of Prevocational Services under the ARChoices waiver program must be certified by the Division of Provider Services and Quality Assurance and must recertify annually.

Reimbursement is not permitted for prevocational services provided by a waiver beneficiary’s:

a. Spouse;
b. Legal guardian of the person; or
c. Attorney-in-fact granted authority to direct the beneficiary’s care.

### 213.700 Respite Care 10-1-16

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<tr>
<td>T1005</td>
<td>Long-Term Facility-Based Respite Care</td>
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<tr>
<td>S5135</td>
<td>Short-Term Facility-Based Respite Care</td>
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<tr>
<td>S5150</td>
<td>In-Home Respite Care</td>
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Respite care services provide temporary relief to persons providing long-term care for beneficiaries in their homes. Respite care may be provided outside of the beneficiary’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 care giving. If there is no primary caregiver, respite care services will not be deemed appropriate and subsequently will not be authorized on the Person-Centered Service Plan (PCSP).

Respite Care is provided to waiver participants unable to care for themselves and is furnished on a limited or short-term basis because of the absence of, or need for relief of, those persons normally providing the care.

Specifically, Respite Care consists of temporary care provided for short term relief for the primary caregiver, subject to the following:

1. The participant lives at home and is cared for, without compensation, by their families or other informal support systems;

2. As determined by the independent assessment, the participant has a severe physical, mental, or cognitive impairment(s) that prevents him or her from being left alone safely in the absence or unavailability of the primary caregiver;

3. The primary caregiver to be relieved is identified and with sufficient documentation that he or she furnishes substantial care of the client comparable to or in excess of services described under the Attendant Care service;

4. No other alternative caregiver (e.g., other member of household, other family member) is available to provide a respite for the primary caregiver(s);

5. Respite Care services are limited to (a) direct human assistance with specific Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks as described under Attendant Care services and (b) supervision necessary to maintain the health and safety of the participant, as supported by the independent assessment and determined medically necessary by the DHS RN; and

6. Respite Care solely serves to supplement (not replace) and otherwise facilitate the continued availability of care provided to waiver participants by families and other informal support systems.

Respite Care is available on a short-term basis (8 hours or less per date of service) or a long-term basis (a full 24 hours per date of service) because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care is available to meet an emergency need or to schedule relief periods in accordance with the regular caregiver’s need for temporary relief from continuous care giving.
Respite Care is available in the following locations:

1. The Participant's home or place of residence;
2. Medicaid-certified hospital;
3. Medicaid-certified nursing facility;
4. Medicaid-certified adult day health facility; and
5. Medicaid-certified assisted living facility with a level II state license.

To allow the person who normally provides care for the waiver participant some time away from his or her caregiving of the participant, Respite Care may be provided in or outside the participant's home as follows:

1. In-home respite may be provided for up to 24 hours per date of service.
2. Facility-based respite care may be provided outside the participant's home on:
   a. A short-term basis (eight (8) hours or less per date of service), or
   b. A long-term (maximum of 24 hours per date of service and used most often when respite needed exceeds the short-term respite amount).

Reimbursement is only permitted for direct care rendered according to the participant’s person-centered service plan by trained respite care workers employed and supervised by certified in-home respite providers.

Respite care is subject to the following limitations:

1. The purpose of Respite Care is to provide respite for unpaid caregivers. The amount, frequency, and duration of Respite Care must be entirely consistent with the amounts, frequencies, and durations of assistance from unpaid caregivers identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards (“THS”). Any amounts, frequencies, or durations in excess of the unpaid caregiver assistance amounts identified for the beneficiary in the THS are not covered.

2. Respite Care excludes:
   a. Skilled health professional services, including physician, nursing, therapist, and pharmacist services.
   b. Services within the scopes of practice of licensed cosmetologists, manicurists, electrologists, or aestheticians, except for necessary assistance with personal hygiene and basic grooming;
   c. Services provided for any other person other than the participant;
   d. Companion, socialization, entertainment, or recreational services or activities of any kind, including, but not limited to, game playing, television watching, arts and crafts, hobbies, and other activities pursued for pleasure, relaxation, or fellowship;
   e. Habilitation services, including but not limited to, assistance in acquiring, retaining, or improving self-help, socialization, and/or adaptive skills; and
   f. Services provided for any tasks not included in a beneficiary’s service plans.

3. Participants are limited to no more than 1,200 hours (4,800 quarter-hour units) per year of in-home respite care, facility-based respite care, or a combination thereof. Respite care is not
subject to a monthly or weekly limit, but is limited to the annual amount of time identified and calculated for the beneficiary in the completed form of the Arkansas Medicaid Task and Hour Standards.

4. Respite Care services are not covered to provide continuous or substitute care while the primary caregiver(s) is working or attending school.

5. Reimbursement is not permitted for Respite Care services provided by a waiver beneficiary’s:
   a. Spouse;
   b. Legal guardian of the person; or
   c. Attorney-in-fact granted authority to direct the beneficiary’s care.

In the event the in-home functional assessments performed by the Independent Assessment Contractor and the Division of Aging and Adult Services Registered Nurse (DAASDHS RN) substantiates a need for respite care services, the service will be authorized as needed, via the beneficiary’s PCSP, not to exceed an hourly maximum. The DAASDHS RN will establish the service limitation based on the beneficiary’s medical need, other services included on the PCSP and support services available to the beneficiary. Respite care services must be provided according to the beneficiary’s written PCSP subject to the participant’s Individual Services Budget.

An individual living in the home with the beneficiary is prohibited from serving as a Respite Services provider for the beneficiary.

213.711 Facility-Based Respite Care

Facility-based respite care may be provided outside the beneficiary’s home on a short- or long-term basis by certified adult family homes, residential care facilities, nursing facilities, adult day care facilities, adult day health care facilities, Level I and Level II Assisted Living Facilities and hospitals.

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

Facility-based providers rendering services for more than 32 units (8 hours) per day must bill T1005 for long-term, facility-based respite care. One (1) unit of service for procedure code T1005 equals 15 minutes. A beneficiary may receive up to 96 units (24 hours) of service per date of service if the provider bills procedure code T1005.

Facility-based respite care services include short-term and long-term respite care services and can include any combination of billing codes S5135 or T1005. A single provider may provide both long-term and short-term facility-based respite care services for a particular beneficiary, but not on the same date of service.

Eligible beneficiaries may receive up to 4800 units (1200 hours) per State Fiscal Year of Facility-Based Respite Care- or In-Home Respite Care, or a combination of the two. Adult Family Home beneficiaries are limited to 2400 units (600 hours) of long-term facility-based respite per state fiscal year.

Beneficiaries receiving long-term, facility-based respite care services may receive only ARChoices Personal Emergency Response System (PERS) services concurrently.
Please refer to the NOTE found in Section 213.500 regarding Home-Delivered Meals and facility-based respite services.

213.712 In-Home Respite Care Certification Requirements 1-1-16

To be certified by the Division of Provider Services and Quality Assurance (DPSQA) Aging and Adult Services (DAAS) as a provider of in-home respite care services, a provider must:

A. Hold a current Class A and/or Class B Home Health Agency license or a Private Care Agency license to provide personal care and/or home health services as issued by the state licensing authority;

B. Employ and supervise direct care staff trained and qualified to provide respite care services; and

C. Agree to the minimum Assurances of Providers of ARChoices Waiver Services.

In-Home Respite Care providers as described in A. above must recertify with DAAS every three years annually; however, DPSQADAAS must maintain a copy of the agency’s current license at all times.

Providers are required to submit copy of renewed license to DPSQADAAS.

NOTE: The Class A, Class B or Private Care Agency license ElderChoices provider’s certification will be valid as a Respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.

213.713 Facility-Based Respite Care Certification Requirements 1-1-16

To be certified by the Division of Aging and Adult Services Provider Services and Quality Assurance (DPSQA) as a provider of facility-based respite care services, a provider must be licensed in their state as one or more of the following:

A. A certified adult family home

A. A licensed adult day care facility

B. A licensed adult day health care facility

C. A licensed nursing facility

D. A licensed residential care facility

E. A licensed Level I or Level II Assisted Living Facility

F. A licensed hospital

Facility-Based Respite Care providers as listed above, with the exception of a certified adult family home, must recertify with DAAS every three years annually; however, DPSQADAAS must maintain a current copy of the facility’s current license at all times.

A certified and Medicaid enrolled adult family home which is also certified by DAAS to provide facility-based respite services must recertify with DAAS annually.

NOTE: The Class A, Class B or Private Care Agency facility-based respite ElderChoices provider’s license certification will be valid as a facility-based respite services provider under the ARChoices Waiver program. The provider will not be required to recertify until the expiration of the previous certification under ElderChoices.
In addition to the service-specific documentation requirements previously listed, ARChoices providers must develop and maintain sufficient written documentation to support each service for which billing is made. This documentation, at a minimum, must consist of:

A. A copy of the beneficiary’s PCSP;

B. A brief description of the specific service(s) provided;

C. The signature and title of the individual rendering the service(s);
   
   1. For records created through an electronic data system such as telephony, computer or other electronic devices, a unique identifier such as a PIN number assigned to and entered by the employee at the time of data input may suffice as an electronic signature and title;
   
   and

D. The date and actual time the service(s) was rendered. For Attendant Care or In-Home Respite Care, it is not necessary to itemize the time spent on each individual ADL or IADL task.

A provider’s failure to maintain sufficient documentation to support his or her billing practices may result in recoupment of Medicaid payment.

No documentation for ARChoices services, as with all Medicaid services, may be made in pencil.

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

A. Person Centered Service Plan — AAS–9503

B. Start Services — AAS–9510

C. Beneficiary Change of Status — AAS–9511

 Providers may request form AAS–9511 by writing to the Division of Aging, Adult, and Behavioral Health Services. View or print the Division of Aging, Adult, and Behavioral Health Services contact information.

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

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

Attendant care, personal care, and prevocational services provided under an authorized PCSP require prior authorization. Services Other services provided under the ARChoices Program under an authorized PCSP do not require prior authorization.
Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at [https://medicaid.mmis.arkansas.gov](https://medicaid.mmis.arkansas.gov) under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

### HCPCS Procedure Codes

The following procedure codes must be billed for ARChoices Services.

Electronic and paper claims now require the same National Place of Service code.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifiers</th>
<th>Description</th>
<th>Unit of Service</th>
<th>National POS for Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5140</td>
<td>Level A – U1, Level B – U2, Level C – U3</td>
<td>Adult Family Homes</td>
<td>1 day</td>
<td>99</td>
</tr>
<tr>
<td>S5125</td>
<td></td>
<td>Attendant Care Services</td>
<td>15 minutes</td>
<td>12</td>
</tr>
<tr>
<td>S5125</td>
<td>U2</td>
<td>Agency Attendant Care Traditional</td>
<td>15 minutes</td>
<td>12, 99</td>
</tr>
<tr>
<td>S5170</td>
<td>U2</td>
<td>Home-Delivered Meals</td>
<td>1 meal</td>
<td>12</td>
</tr>
<tr>
<td>S5170</td>
<td></td>
<td>Frozen Home-Delivered Meal</td>
<td>1 meal</td>
<td>12</td>
</tr>
<tr>
<td>S5170</td>
<td>U1</td>
<td>Emergency Home Delivered Meals</td>
<td>1 meal</td>
<td>12</td>
</tr>
<tr>
<td>S5161</td>
<td>UA</td>
<td>Personal Emergency Response System</td>
<td>1 day</td>
<td>12</td>
</tr>
<tr>
<td>S5160</td>
<td></td>
<td>Personal Emergency Response System – Installation</td>
<td>One install</td>
<td>12</td>
</tr>
<tr>
<td>S5100</td>
<td>U1</td>
<td>Adult Day Services, 8 to 20 units per date of service</td>
<td>15 minutes</td>
<td>99</td>
</tr>
<tr>
<td>S5100</td>
<td></td>
<td>Adult Day Services, 21 to 40 units per date of service</td>
<td>15 minutes</td>
<td>99</td>
</tr>
</tbody>
</table>
## Procedure Codes

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifiers</th>
<th>Description</th>
<th>Unit of Service</th>
<th>National POS for Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5100</td>
<td>TD, U1</td>
<td>Adult Day Health Services, 8 to 20 units per date of service</td>
<td>15 minutes</td>
<td>99</td>
</tr>
<tr>
<td>S5100</td>
<td>TD</td>
<td>Adult Day Health Services, 21 to 40 units per date of service</td>
<td>15 minutes</td>
<td>99</td>
</tr>
<tr>
<td>S5150</td>
<td></td>
<td>Respite Care – In-Home</td>
<td>15 minutes</td>
<td>12</td>
</tr>
<tr>
<td>S5135</td>
<td></td>
<td>Respite Care – Short-Term Facility-Based</td>
<td>15 minutes</td>
<td>99, 21, 32</td>
</tr>
<tr>
<td>T1005</td>
<td></td>
<td>Respite Care – Long-Term Facility-Based</td>
<td>15 minutes</td>
<td>21, 32, 99</td>
</tr>
<tr>
<td>T2015</td>
<td></td>
<td>Prevocational Services Skills Development</td>
<td>15 minutes</td>
<td>11, 12, 99</td>
</tr>
<tr>
<td>T2015</td>
<td>U3</td>
<td>Prevocational Services Career Exploration</td>
<td>15 minutes</td>
<td>11, 12, 99</td>
</tr>
</tbody>
</table>

### 262.210 Place of Service Codes

The national place of service (POS) code is used for both electronic and paper billing.

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>POS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>21</td>
</tr>
<tr>
<td>Beneficiary’s Home</td>
<td>12</td>
</tr>
<tr>
<td>Day Care Facility</td>
<td>99</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>32</td>
</tr>
<tr>
<td>Provider’s Office</td>
<td>11</td>
</tr>
<tr>
<td>Other Locations</td>
<td>99</td>
</tr>
</tbody>
</table>

### 262.400 Special Billing Procedures – Environmental Modifications/Adaptive Equipment

Prior to payment for this service, the ARChoices beneficiary is required to secure three separate itemized bids for the same service. The bids are reviewed by the Division of Aging and Adult Services (DAAS Registered Nurse (DAASDHS RN)) or designee prior to submission for Medicaid payment. If only two bids can be secured due to a shortage of qualified providers in the service area, documentation attesting to the attempt to secure bids and the shortage of providers must be provided.

Each claim must be signed by the provider, the ARChoices beneficiary, and DAASDHS RN, or designee. A statement of satisfaction form must be signed by the ARChoices beneficiary prior to any claim being submitted. Please refer to 213.290 for additional information.