EXHIBIT M

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Section V-4-12 (Form AAS 9559)

DESCRIPTION: The revision of the AAS 9559 adds statements to the claim form to verify the client received attendant care services from their provider according to the plan of care and that the services were satisfactory.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 10, 2012. No public comments were submitted. The proposed effective date is October 1, 2012.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Arkansas Code § 20-76-201 authorizes the Department of Human Services to administer programs for the indigent and to "make rules and regulations" pertaining to the administration of those programs. Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Andrew Allison, PhD
CONTACT PERSON Becky Murphy
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8096 **FAX NO.** 682-2480 **E-MAIL** becky.murphy@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland
PRESENTER E-MAIL marilyn.strickland@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?

   Section V-4-12 (Form AAS 9559)

2. What is the subject of the proposed rule?

   This is a revision to the claim form (AAS 9559) that is completed by consumer directed providers in the Alternatives for Adults with Physical Disabilities (AAPD).

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ___ No _X_.
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes___ No_X_.

   If yes, what is the effective date of the emergency rule?

   When does the emergency rule expire?

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes____ No _____

5. Is this a new rule? Yes___ No __X__ If yes, please provide a brief summary explaining the regulation.

   Does this repeal an existing rule? Yes____ No__X__ If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

   Is this an amendment to an existing rule? Yes__X__ No ___If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

   The purpose of the proposed rule is to revise the claim form used by consumer directed providers of AAPD clients. The proposed rule is necessary to include statements to document the client received services from their attendant care provider according to plan of care, in accordance with Medicaid policy and to their satisfaction.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

   https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes_____ No __X__.
   If yes, please complete the following:
   Date:_____
   Time:_____
   Place:_____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

    July 10, 2012

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

    October 1, 2012

12. Do you expect this rule to be controversial? Yes_____ No __X__ If yes, please explain.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

    Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Connie Parker
TELEPHONE NO. 320-6570 **FAX NO.** 682-2480 **EMAIL:** connie.parker@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – Section V-4-12 (Form AAS 9559)

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ___ No _X_.

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes ___ No _X_.

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

Current Fiscal Year	**Next Fiscal Year**
General Revenue_____	General Revenue_____
Federal Funds_____	Federal Funds_____
Cash Funds_____	Cash Funds_____
Special Revenue_____	Special Revenue_____
Other (Identify)_____	Other (Identify)_____
Total_____	Total_____

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

Current Fiscal Year	**Next Fiscal Year**
None	None

Summary for
Section V-4-12 (Form AAS 9559)

The revision of the AAS 9559 adds statements to the claim form to verify the client received attendant care services from their provider according to the plan of care, in accordance with Medicaid policy and that the services were satisfactory.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

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

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecV-4-12**

PROPOSED

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
AAS-9559	02/2004	AAS-9559	10/2012

Explanation of Updates

The Alternatives Attendant Care Provider Claim Form AAS-9559 has been reformatted as a Microsoft Word document and information on the form has been updated.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 3-4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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

Thank you for your participation in the Arkansas Medicaid Program.

Andy Allison /ks

Andrew Allison, PhD
Director

Alternatives Attendant Care Provider Claim Form

☐ Medicare	☐ Medicaid	☐ CHAMPUS	☐ CAMPVA	☐ Group Health Plan	☐ FECA BLK LUNG	☐ Other	MEDICAID NUMBER
☐ Medicare #	☒ Medicaid #	☐ Sponsor's SSN	☐ VA File #	SSN or ID	☐ SSN	☐ ID	

PATIENT'S NAME (Last name, First name, Middle Initial)	PATIENT'S BIRTHDATE	GENDER	FOR BILLING OFFICE USE ONLY
ADDRESS	Patient Relationship to Insured ☒ Self ☐ Spouse ☐ Child ☐ Other		Procedure Code: **S5125**
CITY / STATE	Patient Status ☐ Single ☐ Married ☐ Other		Type of Service Code: **9**
ZIP CODE / TELEPHONE #	Full Time ☐ Part Time ☐		**Diagnosis Code:**

CLIENT OR AUTHORIZED PERSON'S SIGNATURE (Must be Signed)

I authorize the release of any medical or other information necessary to request payment of government benefits either to myself or to the party who accepts the assignment. I authorize payment of medical benefits to the undersigned. I certify that my attendant caregiver furnished the attendant care services* in accordance with my plan of care and specific directions, and that the services were satisfactory.

SIGNED		DATE	

ATTENDANT CARE BILLING

DATES OF SERVICE		TIME IN	TIME OUT	HOURS WORKED	UNITS WORKED (HOURS X 4)	BILLING AMOUNT (UNITS X $2.43)
DATE	DAY OF WEEK					
					PROPOSED	
			TOTALS			

PROVIDER INFORMATION

NAME:	PIN #:	SSN#:
ADDRESS:		
PHONE #:		

Provider Signature	Date

*Attendant Care Services, Procedure Code S5125, is defined as: assistance to a participant who is medically stable and has a physical disability in accomplishing tasks of daily living that the participant is unable to complete independently. Assistance may vary from actually doing a task for the participant, to assisting the participant to perform the task or to providing safety support while the participant performs the task. Tasks may include the following: Feeding Assistance; Encourage Fluids; Grooming/Oral Care; Bathing; Shampoo; Mobility/Transfer Assistance; Shave; Supervise/Assist with Ambulation; Skin Care; Range of Motion Exercise; Toileting; Meal Preparation; Housekeeping; Laundry; Shopping/Errands/Transportation. Refer to Medicaid Policy Section II for additional information regarding Attendant Care Services and the associated tasks.

Mail Claim Form to:
HP, Alternatives Claims
PO Box 709
Little Rock, AR 72203
1 (800) 457-4454

Mark up

Alternatives Attendant Care Provider Claim Form

☐ Medicare	☐ Medicaid	☐ CHAMPUS	☐ CAMPVA	Group Health Plan ☐	☐ FECA	☐ Other BLK LUNG	MEDICAID NUMBER
☐ Medicare #	☒ Medicaid #	☐ Sponsor's SSN	☐ VA File #	SSN or ID	☐ SSN	☐ ID	

PATIENT'S NAME (Last name, First name, Middle Initial)	PATIENT'S BIRTHDATE	GENDER	FOR BILLING OFFICE USE ONLY Procedure Code: **S5125** Type of Service Code: **9** **Diagnosis Code:**
ADDRESS	Patient Relationship to Insured ☒ Self ☐ Spouse ☐ Child ☐ Other		
CITY / STATE	Patient Status ☐ Single ☐ Married ☐ Other		
ZIP CODE / TELEPHONE #		Full Time ☐ Part Time ☐	

CLIENT OR AUTHORIZED PERSON'S SIGNATURE (Must be Signed)

I authorize the release of any medical or other information necessary to request payment of government benefits either to myself or to the party who accepts the assignment. I authorize payment of medical benefits to the undersigned. I certify that my attendant caregiver furnished the attendant care services* in accordance with my plan of care and specific directions, and that the services were satisfactory.

SIGNED		DATE	

ATTENDANT CARE BILLING

DATES OF SERVICE		TIME IN	TIME OUT	HOURS WORKED	UNITS WORKED (HOURS X 4)	BILLING AMOUNT (UNITS X $2.43)
DATE	DAY OF WEEK					
			TOTALS			

PROVIDER INFORMATION

NAME:	PIN #:	SSN#:
ADDRESS:		
PHONE #:		

Provider Signature	Date

*Attendant Care Services, Procedure Code S5125, is defined as: assistance to a participant who is medically stable and has a physical disability in accomplishing tasks of daily living that the participant is unable to complete independently. Assistance may vary from actually doing a task for the participant, to assisting the participant to perform the task or to providing safety support while the participant performs the task. Tasks may include the following: Feeding Assistance; Encourage Fluids; Grooming/Oral Care; Bathing; Shampoo; Mobility/Transfer Assistance; Shave; Supervise/Assist with Ambulation; Skin Care; Range of Motion Exercise; Toileting; Meal Preparation; Housekeeping; Laundry; Shopping/Errands/Transportation. Refer to Medicaid Policy Section II for additional information regarding Attendant Care Services and the associated tasks.

Mail Claim Form to:
~~EDSHP~~, Alternatives Claims
PO Box 709
Little Rock, AR 72203
1 (800) 457-4454