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200.000 LIVING CHOICES ASSISTED LIVING GENERAL INFORMATION

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

In the text of this manual, the Living Choices Assisted Living Program is generally referred to informally as "Living Choices" or "the Living Choices Program," with a few recurring exceptions. Section headings throughout the manual contain the full name of the program. Certifications, forms or other documents with established legal or regulatory standing are identified by their official name or title, which may include the full name of the Living Choices Program. The complete name of the program is also used wherever needed to help ensure accuracy or clarity.

200.100 Qualifying Criteria for Living Choices Assisted Living Providers 40-43-031-1-13

The following paragraphs identify providers that may qualify as Living Choices providers. Additionally, they provide an overview of Living Choices waiver provider certification and Medicaid provider enrollment for each Living Choices provider category, including some procedural and legal details. Living Choices providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the criteria below to be eligible to participate in the Arkansas Medicaid Program. See Sections 200.110, 200.111, 200.120, and 200.130 for detailed outlines of the additional requirements for provider participation in the Living Choices Assisted Living Program.

- A. Assisted living facilities (ALF) are licensed and regulated by the Office of Long Term Care in the Division of Medical Services (DMS), which is the division of the Arkansas Department of Human Services (DHS) that administers the Arkansas Medicaid Program. Licensed Level II ALF that become certified by the Division of Aging and Adult Services (DAAS, also a division of DHS) as Living Choices Assisted Living Waiver Services Providers are qualified to enroll with Medicaid as Living Choices Assisted Living Facilities—Direct Services Providers if all other requirements for enrollment are met.
- B. Home health agencies in Arkansas are licensed and regulated by the Arkansas Department of Health. Licensed Class A home health agencies may contract with Level II ALF to provide the bundled services covered in the Living Choices Program. In such an arrangement, federal regulations permit Medicaid to cover the services only if the home health agency, instead of the ALF, is the Living Choices provider.

1. DAAS certification as a Living Choices Assisted Living Waiver Services Provider is required to qualify a home health agency for Medicaid enrollment as a Living Choices Assisted Living Agency. Living Choices Assisted Living Waiver Services providers must meet the Provider Participation and enrollment requirements detailed in the Medicaid provider manual.

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

3. The Arkansas State Board of Pharmacy is the certification authority for Consultant Pharmacists in Charge. Consultant Pharmacists in Charge perform legally required quality assurance and patient safety functions with respect to purchasing, storing, handling,

dispensing and administering prescription drugs in institutions such as nursing homes, Level II ALF are required to engage the services of a Consultant Pharmacist in Charge.

1. The Living Choices Assisted Living Program provides for program participants to receive the individual services of a pharmacist consultant.
2. Living Choices Pharmacist Consultant services are similar to Consultant Pharmacist in Charge services, but they are delivered on a resident-specific, rather than facility-wide basis.
3. A licensed pharmacist, certified as a Consultant Pharmacist in Charge by the Arkansas State Board of Pharmacy, may qualify for DAAS certification only by first having a working agreement with a licensed Level II ALF to provide Living Choices Pharmacist Consultant services for Living Choices participants who reside in the ALF. A Consultant Pharmacist in Charge may have such working agreements with more than one ALF.

200.105 Provider Assurances

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A. Staffing

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

The Provider agrees:

1. Personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by, the Department of Human Services. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through DHS.
2. Each service worker possesses the necessary skills to perform the specific services required to meet the needs of the beneficiary he/she is to serve.
3. Staff are required to attend orientation training prior to allowing the employee to deliver any Living Choices Assisted Living Waiver service(s). This orientation shall include, but not be limited to, a:
 - a. Description of the purpose and philosophy of the Living Choices Assisted Living Waiver Program;
 - b. Discussion and distribution of the provider agency's written code of ethics;
 - c. Discussion of activities which shall and shall not be performed by the employee;
 - d. Discussion, including instructions, regarding Living Choices Assisted Living Waiver record keeping requirements;
 - e. Discussion of the importance of the Plan of Care;
 - f. Discussion of the agency's procedure for reporting changes in the beneficiary's condition;
 - g. Discussion, including potential legal ramifications, of the beneficiary's right to confidentiality.

B. Quality Controls

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

C. Code of Ethics

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

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

200.110 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Facilities 40-43-031-1-13

Level II ALF located within the state of Arkansas and licensed by the Arkansas Division of Medical Services, Office of Long Term Care, are eligible to qualify (through DAAS certification) to apply for Medicaid enrollment as Living Choices providers. Qualified Level II Assisted Living Facility providers contract with Medicaid as Living Choices Assisted Living Facility providers to provide and claim reimbursement for Living Choices bundled services instead of contracting with another entity (e.g., a licensed home health agency) that is enrolled with Medicaid to provide and receive payment for those services. Living Choices includes provisions for alternative methods of delivering services because assisted living facilities have different business and staffing arrangements and the Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service. Additional details in this regard are provided in Sections 200.200 through 200.230 this manual.

200.111 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Facilities—Direct Services Providers Reserved 40-8-401-1-13

Effective for dates of service on and after January 1, 2003, DAAS-certified Level II ALF may enroll in Medicaid as Living Choices Assisted Living Facilities—Direct Services Providers. The "Direct Services Provider" label is a designation that presently serves only to further distinguish Living Choices facility providers from Living Choices agency providers, but which may serve a larger purpose as the Living Choices Program undergoes further development.

A Level II Assisted Living Facility must comply with certain criteria and procedures to enroll in Arkansas Medicaid as a Living Choices Assisted Living Facility—Direct Services Provider. This section describes these criteria and procedures, as well as the actions that DAAS and DMS undertake to facilitate the enrollment process.

- A. The facility must be located within the state of Arkansas.
- B. The facility must be licensed by the Arkansas Division of Medical Services, Office of Long Term Care, as a Level II ALF.
- C. The facility must be certified by DAAS as a Living Choices Assisted Living Services Waiver provider.

1. Prospective Living Choices Assisted Living providers may telephone DAAS and press the appropriate number from the menu offered to request an Assisted Living Waiver provider certification application packet, which includes the following:
 - a. Living Choices Assisted Living Waiver Program Provider Certification Application;
 - b. Provider Assurances;
 - c. Division of Medical Services Provider Application (form DMS-652), Medicaid Contract (form DMS-653) and a request for Taxpayer Identification Number and Certification (form W-9). **View or print the DMS-652, DMS-653 and W-9 forms.**
 - d. Living Choices Assisted Living Provider Manual. **View or print DAAS contact information.**

2. The prospective provider must complete the Living Choices Certification Application, Provider Assurances, Medicaid provider application and Medicaid contract, and submit them, signed and dated, with a copy of the Level II Assisted Living Facility license and any documentation required in Sections 200.200 and 200.210, to the Division of Aging and Adult Services. **View or print the Division of Aging and Adult Services contact information.**

3. Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code 25-31-103.

4. When certification is approved, DAAS mails a Living Choices Assisted Living Waiver Services Provider Certificate to the facility and forwards a copy of the certificate to the DMS Provider Enrollment Unit.

D. DAAS also forwards to DMS Provider Enrollment Unit the Living Choices provider application and Medicaid contract.

E. DMS must approve, through established qualifying procedures, all Medicaid provider applications and Medicaid contracts before enrolling providers. In the Living Choices Program, DMS has designated DAAS as the qualifying authority. DAAS certification verifies the provider's qualifications. DMS Provider Enrollment Unit reviews Living Choices provider applications and Medicaid contracts for accuracy and completeness.

1. If the provider application and Medicaid contract are complete and correct, Provider Enrollment Unit assigns a provider number, establishes a provider file and advises the provider of the provider number and the effective date of enrollment.

2. Provider Enrollment Unit contacts providers to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents for correction.

3. The effective date of a provider's enrollment is the most recent of:

- a. The date one year previous to Medicaid's receiving a correct provider application and Medicaid contract;
- b. The effective date of the provider's license, certification or other authorized verification of the provider's qualification to perform a service that he or she is enrolling in Medicaid to provide or
- c. The effective date of a new Medicaid program or the effective date of the addition of a service and its related provider category to an existing Medicaid program.

F. Living Choices ALF must renew their certification annually by submitting to DAAS (**view or print the DAAS contact information**), the current Level II ALF license, the Living Choices Certification Application, Provider Assurances and any required documentation listed in Sections 200.200 and 200.210. Upon renewal of the certification, DAAS will mail

the certificate to the provider and forward a copy of it to DMS Provider Enrollment Unit. Provider Enrollment Unit will update the provider file to reflect the renewal.

200.120 Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Agencies ~~10-13-031-~~
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Within their licensing regulations, Level II ALF may contract with home health agencies and other entities and individuals to provide required and optional services for residents of the ALF. In the Living Choices Program, an ALF that chooses not to be the Medicaid-enrolled provider of Living Choices services may contract only with a licensed ~~DAAS certified~~ home health agency to furnish Living Choices bundled services. The Medicaid authority—the Social Security Act—stipulates that Medicaid must make payment only to the provider of a service. ~~Additional details in this regard are provided in Sections 200.200, 200.210 and 200.230.~~

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

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

- A. The provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.
- B. The provider must submit to ~~DAAS the Medicaid program's Provider Enrollment Unit~~ the following items, in addition to the other documentation required in this section.
 1. A copy of its contract with the ALF (financial details may be omitted). The contract must describe in detail the agency's contractual obligations to provide Living Choices bundled services to the ALF's Living Choices ~~participants/beneficiaries~~.
 2. Copies of contracts (financial details may be omitted) with any entities or individuals the agency has sub-contracted with to provide components of Living Choices bundled services.

~~C. The provider must be certified by DAAS as a Living Choices Assisted Living Services Waiver provider. Procedures for DAAS certification and Medicaid enrollment follow:~~

- ~~1. Prospective Living Choices Assisted Living providers may telephone DAAS and press the appropriate number from the menu offered to request an Assisted Living Waiver provider certification application packet, which includes the following:

 - ~~a. Living Choices Assisted Living Waiver Program Provider Certification Application;~~
 - ~~b. Provider Assurances;~~
 - ~~c. Division of Medical Services Provider Application (form DMS-652), a Medicaid Contract (form DMS-653), and a Request for Taxpayer Identification Number and Certification (form W-9). (View or print the DMS-652, DMS-653 and W-9 forms); and~~
 - ~~d. Living Choices Assisted Living Provider Manual. View or print DAAS contact information.~~~~
- ~~2. The prospective provider must complete the Living Choices Certification Application, Provider Assurances, Medicaid provider Application and Medicaid Contract, and submit the signed and dated documents, with a copy of the Class A Home Health Agency license and the documents required in part B, above, to the Division of Aging~~

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

3. When certification is approved, DAAS mails a *Living Choices Assisted Living Waiver Services Provider Certificate* to the agency and forwards a copy of the certificate to the DMS Provider Enrollment Unit.

D. DAAS also forwards to Provider Enrollment Unit the agency's Living Choices provider application and Medicaid contract.

E. DMS must approve, through established qualifying procedures, all Medicaid provider applications and Medicaid contracts before enrolling providers. In the Living Choices Program, DMS has designated DAAS as the qualifying authority. DAAS certification verifies the provider's qualifications. DMS Provider Enrollment Unit reviews Living Choices provider applications and Medicaid contracts for accuracy and completeness.

1. If the provider application and Medicaid contract are complete and correct, Provider Enrollment Unit assigns a provider number, establishes a provider file and advises the provider of the provider number and the effective date of enrollment.

2. Provider Enrollment Unit contacts providers to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents for correction.

3. The effective date of a provider's enrollment is the most recent of:

a. The date one year previous to Medicaid's receiving a correct provider application and Medicaid contract.

b. The effective date of the provider's license, certification or other authorized verification of the provider's qualification to perform a service that he or she is enrolling in Medicaid to provide, or

c. The effective date of a new Medicaid program or the effective date of the addition of a service and its related provider category to an existing Medicaid program.

F. Living Choices Assisted Living Agencies must renew their certification annually by submitting to DAAS the current Class A Home Health Agency license, the Living Choices Certification Application, Provider Assurances and the documents required in part B, above. Upon renewal of the certification, DAAS will mail the certificate to the provider and forward a copy of it to DMS Provider Enrollment. Provider Enrollment will update the provider file to reflect the renewal. View or print the DAAS contact information.

200.130

Arkansas Medicaid Participation Requirements for Living Choices Assisted Living Pharmacist Consultants Reserved

10-13-031-
1-13

A pharmacist enrolling as a Living Choices Assisted Living Pharmacist Consultant provider must comply with certain criteria and procedures. This section describes those criteria and procedures, as well as actions DMS and DAAS will take to facilitate Medicaid enrollment. A Consultant Pharmacist in Charge must have separate DAAS certification and a separate Medicaid provider number for each ALF in which he or she provides Living Choices Pharmacist Consultant services.

A. The provider must be licensed as a Pharmacist in the state of Arkansas and certified by the Arkansas State Board of Pharmacy as a Consultant Pharmacist in Charge.

B. The provider must have a working agreement with a Level II Assisted Living Facility to provide Living Choices Pharmacist Consultant services. Separate DAAS certification and Medicaid enrollment are required for each such working agreement. In each application for DAAS certification and Medicaid enrollment, the provider must submit to DAAS a copy of his or her working agreement (financial details may be omitted) with an ALF to provide

Living Choices Pharmacist Consultant services, along with the documents required in part C, below:

C. The provider must be certified by DAAS as a Pharmacist Consultant Services Waiver provider.

1. Prospective Pharmacist Consultant Services Waiver providers may telephone DAAS and press the appropriate number from the menu offered to request an Assisted Living Waiver provider certification application packet, which includes the following:

a. Living Choices Assisted Living Waiver Program Provider Certification Application;

b. Provider Assurances;

c. Division of Medical Services Provider Application (form DMS-652), a Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (form W-9) ([View or print DMS-652, DMS-653 and W-9 forms](#)) and

d. Living Choices Assisted Living Provider Manual. [View or print DAAS contact information.](#)

2. The prospective provider must complete the Living Choices Certification Application, Provider Assurances, Provider Application and Medicaid Contract, and submit the signed and dated documents, with a copy of the Pharmacist license, the current Consultant Pharmacist in Charge certification and the copies of working agreements required in part B, above, to the Division of Aging and Adult Services. [View or print Division of Aging and Adult Services contact information.](#)

3. DAAS mails the *Living Choices Assisted Living Waiver Services Provider Certificate* to the provider and forwards a copy to the DMS Provider Enrollment Unit.

D. DAAS also forwards to Provider Enrollment Unit the provider application and Medicaid contract:

1. DMS must approve, through established qualifying procedures, all Medicaid provider applications and Medicaid contracts before enrolling providers. In the Living Choices Program, DMS has designated DAAS as the qualifying authority. DAAS certification verifies the provider's qualifications. DMS Provider Enrollment Unit reviews the Living Choices provider application and Medicaid contract for accuracy and completeness.

2. If the provider application and Medicaid contract are complete and correct, and signed and dated, Provider Enrollment Unit assigns a provider number, establishes a provider file and advises the provider of the provider number and the effective date of enrollment.

3. Provider Enrollment Unit contacts providers to correct errors or omissions in the enrollment documents. Some errors, such as failure to provide an original signature, necessitate returning the documents for correction.

4. The effective date of a provider's enrollment is the most recent of:

a. The date one year previous to Medicaid's receiving a correct provider application and Medicaid contract;

b. The effective date of the provider's license, certification or other authorized verification of the provider's qualification to perform a service that he or she is enrolling in Medicaid to provide; or

c. The effective date of a new Medicaid program or the effective date of the addition of a service and its related provider category to an existing Medicaid program.

~~E. Living Choices Assisted Living Pharmacist Consultants must renew their DAAS certification annually by submitting to DAAS the current Consultant Pharmacist in Charge certification, the Living Choices Certification Application, Provider Assurances and the documents required in part B above. Upon renewal of the certification, DAAS will mail the certificate to the provider and forward a copy of it to DMS Provider Enrollment Unit. Provider Enrollment Unit will update the provider file to reflect the renewal. View or print the DAAS contact information.~~

200.200 Provider Staffing Requirements for the Delivery of Bundled Services

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1-13

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

- A. The referenced sections of the Act require the following.
1. There must be a provider agreement between a state Medicaid agency and each provider furnishing Title XIX (Medicaid) services.
 2. State Medicaid agencies must make payment directly to the providers of services.
 3. Individuals receiving Medicaid benefits must have free choice among available and qualified providers who are willing to furnish the service.
 - a. To be considered "qualified," an individual or entity must meet applicable provider qualifications set forth in the state's Title XIX State Plan or in an approved Medicaid waiver.
 - b. Qualifications must be considered reasonable by the Centers for Medicare and Medicaid Services (CMS).
 - c. CMS considers qualifications reasonable when they are directly related to the demands of the Medicaid service to be furnished.
- B. The requirements—and alternative requirements, if any—set forth in the following sections resulted from CMS interpretations of those three stipulations of the Act. They represent the only legal methods currently available to fulfill staffing needs to deliver Living Choices services. Providers will be notified of alternatives as they are approved and implemented.

~~C. DAAS requires prospective Living Choices providers, as a prerequisite of certification, to disclose their staffing arrangements to ensure that Medicaid payment goes directly to the service provider in accordance with the regulations as interpreted by CMS and set forth in this manual.~~

- ~~1. DAAS requires the disclosure of this information because DMS has designated DAAS as the certifying authority for Living Choices enrollment. Certification by DAAS thus includes confirmation to Medicaid that the provider has furnished assurance of compliance with essential conditions of the Social Security Act.~~
- ~~2. DAAS presumes that employed staff provides a Living Choices component service if no contract is submitted for the delivery of that service.~~

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

40-13-031-
1-13

- A. Medicaid requires a Living Choices ALF—Direct Services Provider to furnish, with its own employees, not with contractors, Living Choices bundled services described in Sections 242-100 through 242-500 of this manual.

1. An individual or entity may not enroll in Medicaid to provide a service or services, and then sub-contract actual service delivery to others. Such arrangements do not satisfy the stipulations of the Social Security Act stated above in Section 200.200.
2. Federal Medicaid regulations do permit an exception to the employee-only rule with respect to one component of Living Choices bundled services. The exception is described in part D.C. of this section.

B. A participant's free choice of providers was a significant consideration in establishing the employee-only rule. If Living Choices bundled services were covered individually, or in several smaller service packages, providers would enroll to furnish one service or one package of services. Each Living Choices provider type would then have its own qualification criteria, based on legal requirements and the demands of the service or services. Living Choices participants would have free choice among all qualified and available providers willing to deliver a service or service package. There could be multiple providers and multiple providers of the same service operating within a single ALF. In the Living Choices Program, a single package of services comprises the services that are directly related to assisted living, and one provider (the ALF or the AL agency) may supply the entire package. An individual found eligible to participate has free choice among available facilities and has free choice whether or not to participate in the Assisted Living Program. If the provider were to sub-contract all of the services to other entities and individuals, the provider would thereby deny to participants their free choice of providers.

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

1. An ALF employee is an individual who is employed by an ALF and who has on file with the ALF administration a current IRS form W-4.
2. Employees providing Living Choices services must be qualified to do so. The provider is responsible for ensuring that all Living Choices services are provided and documented, with documentation retained, in accordance with the provisions of this manual.

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

E. There is also a legal alternative to the employee-only requirement by which a provider is not mandated to provide every required or covered service through employees. That alternative method is not yet available in the Living Choices Program. This manual will be updated to include the alternative method as soon as the State receives CMS approval to allow it.

beneficiary satisfaction and quality of service delivery and to record their findings every 90 days by completing the Quarterly Monitoring Form (AAS-9506), and to notify the DAAS RN in writing within one week of services being terminated documenting the termination effective date and the reason for termination.

202.200

Records that Living Choices Assisted Living Pharmacist Consultants Must Keep Reserved

40-13-031-
1-13

Living Choices Pharmacist consultants must maintain records as required by their Consultant Pharmacist in Charge certification.

210.000 PROGRAM COVERAGE

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

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

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

211.000

Scope of the Program

40-13-031-
1-13

Section 300 of the Level II Assisted Living Facilities Rules and Regulations manual defines assisted living as: "Housing, meals, laundry, social activities, transportation (assistance with and arranging for transportation), one or more personal services, direct care services, health care services, 24-hour supervision and care, and limited nursing services." Medicaid, by federal law, may not cover beneficiaries' room and board except in nursing and intermediate care facilities. Medicaid covers some services only under certain conditions. Of the services listed above, Arkansas Medicaid covers many health care services, personal care services and medical transportation under its Title XIX (Medicaid) State Plan. However, the federal rules and regulations governing Medicaid State Plan services create barriers to providing the type of individualized packages of services that make assisted living an effective and attractive alternative to living alone or in a nursing home. This home and community-based services waiver program permits Medicaid coverage of assisted living services that otherwise could not be covered as described in this manual.

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

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

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

211.100 Eligibility for the Living Choices Assisted Living Program

7-45-421-1-
13

- A. Individuals may participate in the Living Choices Assisted Living Program only as residents of licensed Level II Assisted Living Facilities (ALF). To qualify for the Living Choices Program, an individual must meet the targeted population as described in this manual: be aged 65 or older, or age 21 or older and blind or an individual with a physical disability as determined by the Social Security Administration (SSA) or the Department of Human Services (DHS) Medical Review Team; and must be found to require a nursing facility intermediate level of care. Individuals meeting the required skilled level of care nursing care, as determined by the Office of Long Term Care, are not eligible for the Living Choices Assisted Living Program.

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

- B. Candidates for participation in the program (or their representatives) must make an application for services at the DHS office in the county in which the Level II ALF is located. Eligibility/Medicaid eligibility is determined by the DHS County Office and is based on non-medical and medical criteria. Income and resources comprise the non-medical criteria. Medically, the candidate must be an individual with a functional disability.
- C. To be determined an individual with a functional disability, an individual must meet at least one of the following three criteria, as determined by a licensed medical professional.
1. The individual is unable to perform either of the following:
 - a. At least 1 of the 3 activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon, another person; or
 - b. At least 2 of the 3 ADLs of transferring/locomotion, eating or toileting without limited assistance from another person; or
 2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired, requiring substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or others; Medical assessment results in a score of three or more on Cognitive Performance Scale; or
 3. The individual has a diagnosed medical condition that requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life threatening; Medical assessment results in a Changes in Health, End-Stage Disease and Symptoms and Signs (CHES) score of three or more.

- D. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition that is temporary and expected to last no more than 21 days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition that would render the individual ineligible if the condition or change in condition is expected to last more than 21 days.
- E. Individuals diagnosed with a serious mental illness, ~~except as specified in part C above~~, or mental retardation are not eligible for the Living Choices Assisted Living program unless they have medical needs unrelated to the diagnosis of mental illness or mental retardation and meet the other qualifying criteria. A diagnosis of severe mental illness or mental retardation must not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation when they meet the other qualifying criteria.

~~F. Registered Nurses (RNs) employed by the Division of Aging and Adult Services (DAAS) perform a comprehensive assessment of each applicant to determine his or her personal assistance and health care needs. The assessment tool is the Assisted Living Comprehensive Assessment (View or print form AAS-9565) which establishes the candidate's tier of need. There are four tiers of need in the Living Choices Program, each tier progressively requiring more bundled services.~~

~~G. DAAS nurses perform periodic reevaluations (at least annually) of the need for a nursing home/intermediate level of care. Reevaluations must be performed more often if needed to ensure that a resident is appropriately placed in the Living Choices Assisted Living Program and is receiving services suitable to his or her needs. F. Eligibility for the Living Choices waiver program is determined as the latter of the date of application for the program, the date of admission to the assisted living facility or the date the plan of care is signed by the DAAS RN and beneficiary. (If a waiting list is implemented in order to remain in compliance with the waiver application as approved by CMS, the eligibility date determination will be based on the waiting list process.)~~

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

- ~~1. Each Living Choices application will be accepted and medical and financial eligibility will be determined.~~
- ~~2. If all waiver slots are filled, the applicant will be notified of his or her eligibility for services, that all waiver slots are filled, and that the applicant is number X in line for an available slot.~~
- ~~3. Entry to the waiver will then be prioritized based on the following criteria:~~
 - ~~a. Waiver application determination date for persons inadvertently omitted from the waiver waiting list due to administrative error.~~
 - ~~b. Waiver application determination date for persons being discharged from a nursing facility after a 90-day stay, waiver application determination date for persons residing in an approved Level II Assisted Living Facility for the past six months or longer.~~
 - ~~c. Waiver application determination date for persons in the custody of DHS Adult Protective Services (APS).~~
 - ~~d. Waiver application determination date for all other persons.~~

211.150 Level of Care Determination**1-1-13**

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

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

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

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

211.200 Plan of Care**6-4-091-1-13**

Assisted living residents negotiate, execute and sign an occupancy admission agreement with the assisted living provider. Each occupancy admission agreement contains a health care services section (if a health assessment establishes that there are health care needs) and a direct care services section. Not all residents have a health care services section. Some residents may have a health care services section only periodically.

A. Each beneficiary in the Living Choices Assisted Living Program must have an individualized Living Choices Plan of Care (AAS-9503). The authority to develop a Living Choices plan of care is given to the Medicaid State agency's designee, the Division of Aging and Adult Services Registered Nurse (DAAS RN). The Living Choices plan of care developed by the DAAS RN, all of a beneficiary's services comprise a single plan of care. DAAS RNs develop, for each Living Choices Program beneficiary, an assisted living plan of care that notes the beneficiary's tier of need and includes all services the beneficiary must receive includes, but is not limited to:

1. Beneficiary identification and contact information to include full name and address, phone number, date of birth, Medicaid number and the effective date of Living Choices Assisted Living waiver eligibility.
2. Primary and secondary diagnosis.
3. Tier Level.
4. Contact person.
5. Physician's name and address.
6. The amount, frequency and duration of required Living Choices services and the name of the service provider chosen by the beneficiary or representative to provide the services.
7. Other services outside the Living Choices services, regardless of payment source identified and/or ordered to meet the beneficiary's needs. Living Choices providers are not required to provide these services, but they may not impede their delivery.
8. The election of community services by the waiver beneficiary, and

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

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

2. The plan of care specifies the amount, frequency and duration of required Living Choices services.

3. The plan of care lists other necessary Medicaid covered services and their amount, frequency and duration. Living Choices providers are not required to provide these services, but they may not impede their delivery.

4. The plan of care also lists ordered services that are not covered under the Medicaid State Plan or the Living Choices Assisted Living Program. Living Choices providers are not required to provide these services, but they may not impede their delivery.

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

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

1. Individualized to the beneficiary's unique circumstances.

2. Provided in the least restrictive environment possible.

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

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

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

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

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

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

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

CD. The DAAS RN must reevaluate a beneficiary's medical condition plan of care within fourteen days of being notified of any significant change in the beneficiary's condition. The

assisted living RN is responsible for immediately notifying the DAAS RN regarding beneficiaries whose status or condition has changed and who need reevaluation and reassessment.

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

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

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

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

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

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

D. Except under the circumstances listed below in part E, the plan of care must be authorized by the beneficiary's physician, who must sign and date it before services may begin.

E. In urgent circumstances (in which, without immediate initiation of assisted living services, an individual is at imminent risk of institutional placement) an individual may be placed in a Level II Assisted Living Facility under a provisional plan of care developed by the beneficiary and the DAAS RN and signed by the beneficiary or the beneficiary's representative and the DAAS RN.

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

2. A plan of care that has been approved and signed by the beneficiary's physician must be in place no later than the end date of the provisional plan of care.

F. Services not listed in the plan of care (whether provisional or physician approved) are not covered by Arkansas Medicaid.

212.000 Living Choices Assisted Living Services

**6-4-081-1-
13**

Once a Living Choices eligibility application has been approved, waiver services must be provided in order for eligibility to continue. Medicaid covers Living Choices services on a daily, all-inclusive basis, rather than on an itemized per-service basis. With the exception explained in the NOTE below, a day is a covered date of service when a participant beneficiary receives any of the services described as a covered ALF service in Sections 212.100 through 212.500 this manual when the service is received between midnight on a given day and midnight of the following day. A day is not a covered date of service when a participant beneficiary does not receive any Living Choices services between midnight of that day and midnight of the following day.

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

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

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

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

6/11/12 – Reimbursement to the hospital

6/12/12 – Reimbursement to the hospital

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

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

- A. Basic Living Choices Assisted Living direct care services are:
1. Attendant care services,
 2. Therapeutic social and recreational activities,
 3. Periodic nursing evaluations,
 4. Limited nursing services,
 5. Assistance with medication to the extent that such assistance is in accordance with the Arkansas Nurse Practice Act and interpretations thereto by the Arkansas Board of Nursing,
 6. Medication oversight to the extent permitted under Arkansas law and
 7. Assistance obtaining non-medical transportation specified in the plan of care.
- B. Living Choices participants are eligible for pharmacist consultant services. Level II ALFs are required by their licensing regulations to engage a Consultant Pharmacist in Charge.

~~Consultant Pharmacists in Charge may enroll in the Living Choices Program to provide individualized pharmacy consultant services in accordance with Living Choices participants' plans of care.~~

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

~~C~~ Living Choices waiver participants/beneficiaries are eligible for the same prescription drug benefits of regular Medicaid, plus three (3) additional prescriptions for a total of nine (9) per month. No prior authorization is required for the three additional prescriptions. Living Choices waiver participants/beneficiaries who are dual eligibles (receiving both Medicare and Medicaid)

must obtain prescribed medications through the Medicare Part D Prescription Drug Plan, or for certain prescribed medications excluded from the Medicare Part D Prescription Drug Plan, through the Arkansas Medicaid State Plan Pharmacy Program.

212.100 Attendant Care Services

40-13-031-
1-13

- A. Attendant care is a direct care service to help a medically stable individual who has physical dependency needs in accomplishing activities and tasks of daily living that the individual is usually or always unable to perform independently.
1. Living Choices ~~participants/beneficiaries~~ are furnished attendant care on an individualized basis for assistance with eating and nutrition, dressing, bathing and personal hygiene, mobility and ambulation, and bowel and bladder requirements.
 2. Attendant care may include assistance with incidental housekeeping and shopping for personal care items or food.
 3. With regard to assistance with medication (for residents who elect to self-administer their medications) attendant care services include only the very limited functions detailed in Section 702.1.1.5F of the Level II Assisted Living Facilities Rules and Regulations.
- B. Activities that constitute assisting a person with physical dependency needs vary.
1. One might perform the entire task (e.g., buttoning his shirt for him), or assist the person in performing the task (e.g., helping him line up button and buttonhole).
 2. Assistance might consist of simply providing safety support while the person performs the task (e.g., providing support so he can let go of his cane while he buttons his shirt).
 3. Attendant care services may include supervision, visual or auditory cueing, or only observation of a person performing a task or activity to ensure completion of the activity or the safety of the individual.
- C. The assisted living provider RN's attendant care instructions must be based ~~at a minimum~~ on the ~~waiver~~ plan of care.
- D. The minimum qualifications of an individual providing attendant care in the Living Choices Program are those of a certified personal care aide. See ~~Sections 216.000 through 216.260~~ for personal care aide training and certification requirements ~~in this manual~~.
- E. Individuals participating in the Living Choices Program are not eligible to access personal care services or extended personal care services through the Arkansas Medicaid Personal Care Program.

212.200 Periodic Nursing Evaluations

40-13-031-
1-13

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

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

212.310 Registered Nurse (RN) Limited Nursing Services 40-43-031-
1-13

RN limited nursing services include:

- A. Assessing each Living Choices ~~participant's beneficiary's~~ health care needs,
- B. Implementing and coordinating the delivery of services ordered on the assisted living plan of care,
- C. Monitoring and assessing the ~~participant's beneficiary's~~ health status on a periodic basis,
- D. Administering medication and delivering limited medical services as provided by Arkansas law and applicable regulations and
- E. Making referrals to physicians or community agencies as appropriate.

212.320 Licensed Practical Nurse (LPN) Limited Nursing Services 40-43-031-
1-13

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

- A. Monitoring each waiver ~~participant's beneficiary's~~ health status,
- B. Administering medication and delivering limited medical services as provided by Arkansas law or applicable regulation and
- C. Notifying the RN if there are significant changes in a ~~participant's beneficiary's~~ health status.

212.500 Non-Medical Transportation 40-43-031-
1-13

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

212.600 ~~Pharmacist Consultant Services Reserved~~ 40-43-031-
1-13

~~Living Choices Pharmacist Consultant services are the duties required by the Level II Assisted Living Facility Regulations for Consultant Pharmacists in Charge.~~

213.000 Additional Services 40-43-031-
1-13

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

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

214.000 Benefit Limits 6-4-081-1-13

- A. ~~There are no benefit limits applicable to the Living Choices Assisted Living bundled services are limited to one unit per day and pharmacist consultant benefits.~~
- B. Living Choices Assisted Living Program ~~participants/beneficiaries~~ may have as many as nine prescription drugs per month covered by Medicaid. Dual eligibles, receiving both Medicare and Medicaid, receive prescription drug coverage through Part D Medicare. Medicare has no restrictions on the number of prescription drugs that can be received during a month. Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

215.000 Living Choices Forms**1-1-13**

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

- A. ~~Plan of Care – AAS-9503~~
- B. ~~Quarterly Monitoring – AAS-9506~~
- C. ~~Start Services – AAS-9510~~
- D. ~~Beneficiary Change of Status – AAS-9511~~

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

~~Forms AAS-9503 and AAS-9510 will be mailed to the provider by the DHS RN.~~

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

216.200 Personal Care Aide Training Subject Areas**40-13-031-
1-13**

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

- A. Correct conduct toward ~~clients/beneficiaries~~, including respect for the ~~client/beneficiary~~, the ~~client's/beneficiary's~~ privacy and the ~~client's/beneficiary's~~ property.
- B. Understanding and following spoken and written instructions.
- C. Communications skills, especially the skills needed to:
1. Interact with ~~clients/beneficiaries~~,
 2. Report relevant and required information to supervisors and
 3. Report events accurately to public safety personnel and to emergency and medical personnel.
- D. Record-keeping, including:
1. The role and importance of record keeping and documentation,
 2. Service documentation requirements and procedures,
 3. Reporting and documenting non-medical observations of ~~client/beneficiary~~ status and
 4. Reporting and documenting, when pertinent, the ~~client's/beneficiary's~~ observations regarding his or her own status.

- E. Recognizing and reporting to the supervising RN changes in the ~~client's beneficiary's~~ condition or status that require the aide to perform tasks differently than instructed.
- F. State law regarding delegation of nursing tasks to unlicensed personnel.
- G. Basic elements of body functioning, and the types of changes in body function, easily recognizable by a layperson, that an aide must report to a supervisor.
- H. Safe transfer techniques and ambulation.
- I. Normal range of motion and positioning.
- J. Recognizing emergencies and knowledge of emergency procedures.
- K. Basic household safety and fire prevention.
- L. Maintaining a clean, safe and healthy environment.
- M. Instruction in appropriate and safe techniques in personal hygiene and grooming that include how to assist the ~~client beneficiary~~ with:
 - 1. Bed bath,
 - 2. Sponge, tub or shower bath,
 - 3. Shampoo (sink, tub or bed),
 - 4. Nail and skin care,
 - 5. Oral hygiene,
 - 6. Toileting and elimination,
 - 7. Shaving,
 - 8. Assistance with eating,
 - 9. Assistance with dressing,
 - 10. Efficient, safe and sanitary meal preparation,
 - 11. Dishwashing,
 - 12. Basic housekeeping procedures and
 - 13. Laundry skills.

216.210 Personal Care Aide Training Requirements40-43-031-
1-13

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

- A. Minimum classroom training time is 24 hours.
- B. Minimum time for supervised practical training is 16 hours.
 - 1. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge by performing tasks on an individual while the trainee is under supervision.
 - 2. Trainees must complete at least 16 hours of classroom training before beginning any supervised practical training.
 - 3. Supervised practical training may occur at locations other than the site of the classroom training.
 - a. Trainees must complete at least 24 hours of classroom training before undertaking any supervised practical training that involves Living Choices

- ~~participants/beneficiaries~~ or Medicaid-eligible individuals who receive Arkansas Medicaid Personal Care services.
- b. The training program must have the written consent of Living Choices ~~participants/beneficiaries~~ or other Medicaid-eligible individuals (or their representatives) if aide trainees furnish any Attendant Care or personal care to those individuals as part of the supervised practical training.
 - ~~(1)~~i. A copy of each such consent must be maintained in the trainee's file.
 - ~~(2)~~ii. The ~~participant's/beneficiary's~~ (or the personal care ~~beneficiary/client's~~) daily service documentation must include the names of the supervising RN and the personal care aide trainees.
4. The training of personal care aides and the supervision of personal care aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse with current Arkansas licensure.
- a. The qualified registered nurse must possess a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of in-home health care.
 - b. Other individuals may provide instruction under the supervision of the qualified registered nurse.
 - c. Supervised practical training with a consenting Living Choices ~~participant/beneficiary~~ or personal care ~~client/beneficiary~~ as the subject must be personally supervised by:
 - ~~(1)~~i. A qualified registered nurse or
 - ~~(2)~~ii. A licensed practical nurse under the general supervision of the qualified registered nurse.

216.220

Personal Care Aide Training Documentation40-13-031-
1-13

- A. Medicaid requires the following documentation of training:
1. The number of hours each of classroom instruction and supervised practical training.
 2. Names and qualifications of instructors and current copies of licenses of supervising registered nurses.
 3. Street addresses and physical locations of training sites, including facility names when applicable.
 4. If the training includes any supervised practical training in the homes of personal care ~~clients/beneficiaries~~ or in the residences of Living Choices ~~participants/beneficiaries~~, the forms documenting the ~~client's/beneficiary's~~ or resident's consent to the training in their home.
 5. The course outline.
 6. Lesson plans.
 7. A brief description of the instructor's methods of supervising trainees during practical training.
 8. The training program's methods and standards for determining whether a trainee can read and write well enough to perform satisfactorily the duties of a personal care aide.
 9. The training program's method of evaluating written tests, oral exams (if any) and skills tests, including the relative weights of each in the minimum standard for successful completion of the course.
 10. The training program's minimum standard for successful completion of the course.

11. Evidence and documentation of successful completions (certificates supported by internal records).

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

216.240 Personal Care Aide Selection

**40-13-031-
1-13**

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

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

1. A spouse.

2. A ~~legal guardian of the person or anyone acting as a "guardian of the person"~~

3. ~~An attorney-in-fact authorized to direct care for the beneficiary.~~

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

1. A sympathetic attitude toward the care of the sick,

2. An ability to read, write and carry out directions and

3. Maturity and ability to deal effectively with the demands of the job.

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

1. Are certified as personal care aides,

2. Participate in all required in-service training and

3. Maintain at least "satisfactory" competency evaluations from their supervisors in all attendant care tasks they perform.

216.260 In-Service Training

**40-13-031-
1-13**

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

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

1. When appropriate, in-service training may occur at an assisted living facility when the aide is furnishing services.

2. In-service training while serving a Living Choices ~~participant beneficiary~~ may occur only if the ~~participant beneficiary~~ or the ~~participant's beneficiary's~~ representative has given prior written consent for training activities to occur concurrently with the ~~participant's beneficiary's~~ care.

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

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

250.100 Reimbursement of Living Choices Assisted Living Facilities and Agencies

**40-13-031-
1-13**

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

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

250.200 Reimbursement of Living Choices Assisted Living Pharmacist Consultants Reserved 40-13-031-1-13

Reimbursement of pharmacist consultants is a daily fee, paid at the lesser of the billed charge or the Medicaid maximum allowable fee. The pharmacist consultant's services for individual residents may occur over several days, and the provider may bill Medicaid for a span of consecutive days, but the pharmacist consultant may bill Medicaid only one time per month, per participant.

262.100 Living Choices Assisted Living Procedure Codes 6-4-081-1-13

Procedure Code	Modifier	Description
T2031	U1	Living Choices Assisted Living Tier 1
T2031	U2	Living Choices Assisted Living Tier 2
T2031	U3	Living Choices Assisted Living Tier 3
T2031	U4	Living Choices Assisted Living Tier 4
<u>Z2789</u>		<u>Living Choices Assisted Living Pharmacist Consultant</u>

*Bill on paper only

262.310 Completion of CMS-1500 Claim Form 6-4-081-1-13

Field Number and Name	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	<u>Participant's Beneficiary's</u> 10-digit Medicaid identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	<u>Participant's Beneficiary's</u> last name and first name.
3. PATIENT'S BIRTH DATE	<u>Participant's Beneficiary's</u> date of birth as given on the individual's Medicaid identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.

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

Field Number and Name	Instructions for Completion
10d. RESERVED FOR LOCAL USE	Not used.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Not required.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not required.
19. RESERVED FOR LOCAL USE	Not used.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.

Field Number and Name	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	ICD-9-CM diagnosis code for the client's beneficiary's primary medical condition. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) diagnosis coding current as of the date of service.
22. MEDICAID RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Reserved for future use.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Not required.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the provider's usual charge to any client/beneficiary .
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Not required.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Not required.

Field Number and Name	Instructions for Completion
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid co-payments.
30. BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	Enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

262.420

Dates of Service

10-13-031-
1-13

Dates of service may be itemized or expressed in a date of service range; i.e., "From Date" and "Through Date." A date of service range may include only covered days. A day is a covered date of service when a participant receives any of the services described in Sections 212.100 through 212.600 of this manual, between midnight on a given day and midnight of the following day. A day is not a covered date of service when a participant does not receive any Living Choices services between midnight of that day and midnight of the following day.

262.430

Pharmacist Consultant Billing Reserved

10-13-031-

1-13

A Pharmacist Consultant may bill for one day (one unit) of service for one Living Choices participant if he or she performs any Pharmacist Consultant services for that participant on a given day, no matter how minimal the service. All of the services performed for a participant during a calendar month must be billed on one claim. Pharmacist consultants may bill Medicaid for the total number of days in a month on which a service was performed, but they may submit to Medicaid only one claim per client per month. It is permissible to bill for several sequential days in a single claim detail if a service was provided on each day in the sequence.

SECTION V – FORMS**500.000****Claim Forms****Red-ink Claim Forms**

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

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

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

Claim Forms

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

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

Arkansas Medicaid Forms

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

In order by form name:

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

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	<u>DMS-679A</u>
Amplification/Assistive Technology Recommendation Form	<u>DMS-686</u>
Application for WebRA Hardship Waiver	<u>DMS-7736</u>
Approval/Denial Codes for Inpatient Psychiatric Services	<u>DMS-2687</u>
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	<u>DDS/FS#0001.a</u>
ARKids First Mental Health Services Provider Qualification Form	<u>DMS-612</u>
Assisted Living Waiver Plan of Care	<u>AAS-9565</u>
Authorization for Automatic Deposit	<u>autodeposit</u>
Authorization for Payment for Services Provided	<u>MAP-8</u>
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2633</u>
Certification of Schools to Provide Comprehensive EPSDT Services	<u>CSPC-EPSDT</u>
Certification Statement for Abortion	<u>DMS-2698</u>
Change of Ownership Information	<u>DMS-0688</u>
Child Health Management Services Enrollment Orders	<u>DMS-201</u>
Child Health Management Services Discharge Notification Form	<u>DMS-202</u>
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	<u>DMS-699A</u>
CHMS Request for Prior Authorization	<u>DMS-102</u>
Claim Correction Request	<u>DMS-2647</u>
Consent for Release of Information	<u>DMS-619</u>
Contact Lens Prior Authorization Request Form	<u>DMS-0101</u>
Contract to Participate in the Arkansas Medical Assistance Program	<u>DMS-653</u>
DDTCS Transportation Log	<u>DMS-638</u>
DDTCS Transportation Survey	<u>DMS-632</u>
Dental Treatment Additional Information	<u>DMS-32-A</u>
Disclosure of Significant Business Transactions	<u>DMS-689</u>
Disproportionate Share Questionnaire	<u>DMS-628</u>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	<u>DMS-693</u>
Early Childhood Special Education Referral Form	<u>ECSE-R</u>
EPSDT Provider Agreement	<u>DMS-831</u>
Explanation of Check Refund	<u>HP-CR-002</u>
Gait Analysis Full Body	<u>DMS-647</u>

Form Name	Form Link
Home Health Certification and Plan of Care	<u>CMS-485</u>
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	<u>DCO-645</u>
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	<u>DMS-2685</u>
Individual Renewal Form for School-Based Audiologists	<u>DMS-7782</u>
Lower-Limb Prosthetic Evaluation	<u>DMS-650</u>
Lower-Limb Prosthetic Prescription	<u>DMS-651</u>
Media Selection/E-Mail Address Change Form	<u>HP-MS-005</u>
Medicaid Claim Inquiry Form	<u>HP-CI-003</u>
Medicaid Form Request	<u>HP-MFR-001</u>
Medical Assistance Dental Disposition	<u>DMS-2635</u>
Medical Equipment Request for Prior Authorization & Prescription	<u>DMS-679</u>
Medical Transportation and Personal Assistant Verification	<u>DMS-616</u>
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	<u>DMS-633</u>
Notice Of Noncompliance	<u>DMS-635</u>
NPI Reporting Form	<u>DMS-683</u>
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	<u>DMS-640</u>
Ownership and Conviction Disclosure	<u>DMS-675</u>
Personal Care Assessment and Service Plan	<u>DMS-618 English</u> <u>DMS-618 Spanish</u>
Practitioner Identification Number Request Form	<u>DMS-7708</u>
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	<u>DMS-2615</u>
Primary Care Physician Managed Care Program Referral Form	<u>DMS-2610</u>
Primary Care Physician Participation Agreement	<u>DMS-2608</u>
Primary Care Physician Selection and Change Form	<u>DMS-2609</u>
Prior Authorization-(PA) Request for Extension of Benefits-Prescription Drugs	<u>DMS-0685-14</u>
Procedure Code/NDC Detail Attachment Form	<u>DMS-664</u>
Provider Application	<u>DMS-652</u>
Provider Communication Form	<u>AAS-9502</u>
Provider Data Sharing Agreement – Medicare Parts C & D	<u>DMS-652-A</u>
Provider Enrollment Application and Contract Package	<u>AppMaterial</u>
Quarterly Monitoring Form	<u>AAS-9506</u>

Form Name	Form Link
Referral for Audiology Services – School-Based Setting	<u>DMS-7783</u>
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2634</u>
Referral for Medical Assistance	<u>DMS-630</u>
Request for Appeal	<u>DMS-840</u>
Request for Extension of Benefits	<u>DMS-699</u>
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	<u>DMS-671</u>
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	<u>DMS-602</u>
Request For Orthodontic Treatment	<u>DMS-32-0</u>
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	<u>DMS-2692</u>
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	<u>DMS-601</u>
Research Request Form	<u>HP-0288</u>
Service Log – Personal Care Delivery and Aides Notes	<u>DMS-873</u>
Sterilization Consent Form	<u>DMS-615 English</u> <u>DMS-615 Spanish</u>
Sterilization Consent Form – Information for Men	<u>PUB-020</u>
Sterilization Consent Form – Information for Women	<u>PUB-019</u>
Upper-Limb Prosthetic Evaluation	<u>DMS-648</u>
Upper-Limb Prosthetic Prescription	<u>DMS-649</u>
Vendor Performance Report	<u>Vendorperformreport</u>
Verification of Medical Services	<u>DMS-2618</u>

In order by form number:

<u>AAS-9502</u>	<u>DMS-2610</u>	<u>DMS-615</u>	<u>DMS-652-A</u>	<u>DMS-873</u>
<u>AAS-9559</u>	<u>DMS-2615</u>	<u>Spanish</u>	<u>DMS-653</u>	<u>ECSE-R</u>
<u>AAS-9565</u>	<u>DMS-2618</u>	<u>DMS-616</u>	<u>DMS-664</u>	<u>HP-0288</u>
<u>AAS-9506</u>	<u>DMS-2633</u>	<u>DMS-618</u>	<u>DMS-671</u>	<u>HP-AR-004</u>
<u>Address</u>	<u>DMS-2634</u>	<u>English</u>	<u>DMS-675</u>	<u>HP-CI-003</u>
<u>Change</u>	<u>DMS-2635</u>	<u>DMS-618</u>	<u>DMS-673</u>	<u>HP-CR-002</u>
<u>Autodeposit</u>	<u>DMS-2647</u>	<u>Spanish</u>	<u>DMS-679</u>	<u>HP-MFR-001</u>
<u>CMS-485</u>	<u>DMS-2685</u>	<u>DMS-619</u>	<u>DMS-679A</u>	<u>HP-MS-005</u>
<u>CSPC-EPSDT</u>	<u>DMS-2687</u>	<u>DMS-628</u>	<u>DMS-683</u>	<u>MAP-8</u>
<u>DCO-645</u>	<u>DMS-2692</u>	<u>DMS-630</u>	<u>DMS-686</u>	<u>Performance</u>
<u>DDS/FS#0001.a</u>	<u>DMS-2698</u>	<u>DMS-632</u>	<u>DMS-689</u>	<u>Report</u>
<u>DMS-0101</u>	<u>DMS-2704</u>	<u>DMS-633</u>	<u>DMS-693</u>	<u>Provider</u>
<u>DMS-0685-14</u>	<u>DMS-32-A</u>	<u>DMS-635</u>	<u>DMS-699</u>	<u>Enrollment</u>
<u>DMS-0688</u>	<u>DMS-32-0</u>	<u>DMS-638</u>	<u>DMS-699A</u>	<u>Application</u>
<u>DMS-102</u>	<u>DMS-601</u>	<u>DMS-640</u>	<u>DMS-7708</u>	<u>and Contract</u>
<u>DMS-201</u>	<u>DMS-602</u>	<u>DMS-647</u>	<u>DMS-7736</u>	<u>Package</u>
<u>DMS-202</u>	<u>DMS-612</u>	<u>DMS-648</u>	<u>DMS-7782</u>	<u>PUB-019</u>
<u>DMS-2606</u>	<u>DMS-615</u>	<u>DMS-649</u>	<u>DMS-7783</u>	<u>PUB-020</u>
<u>DMS-2608</u>	<u>English</u>	<u>DMS-650</u>	<u>DMS-831</u>	
<u>DMS-2609</u>		<u>DMS-651</u>	<u>DMS-840</u>	
		<u>DMS-652</u>		

Arkansas Medicaid Contacts and Links

Click the link to view the information.

[American Hospital Association](#)

[Americans with Disabilities Act Coordinator](#)

[Arkansas Department of Education, Health and Nursing Services Specialist](#)

[Arkansas Department of Education, Special Education](#)

[Arkansas Department of Human Services, Division of Aging and Adult Services](#)

[Arkansas Department of Human Services, Appeals and Hearings Section](#)

[Arkansas Department of Human Services, Division of Behavioral Health Services](#)

[Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit](#)

[Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit](#)

[Arkansas Department of Human Services, Children's Services](#)

Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, HP Enterprise Services Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

Arkansas DHS, Division of Medical Services, Medical Director

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Program Integrity Unit (PI)

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

Arkansas DHS, Division of Medical Services, Third-Party Liability Unit

Arkansas DHS, Division of Medical Services, UR/Home Health Extensions

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation For Medical Care

Arkansas Hospital Association

ARKids First-B

ARKids First-B ID Card Example

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

CPT Ordering

Dental Contractor

HP Enterprise Services Claims Department

HP Enterprise Services EDI Support Center (formerly AEVCS Help Desk)

HP Enterprise Services Inquiry Unit

HP Enterprise Services Manual Order

HP Enterprise Services Pharmacy Help Desk

[HP Enterprise Services Provider Assistance Center \(PAC\)](#)

[HP Enterprise Services Supplied Forms](#)

[Example of Beneficiary Notification of Denied ARKids First-B Claim](#)

[Example of Beneficiary Notification of Denied Medicaid Claim](#)

[First Connections Infant & Toddler Program, Developmental Disabilities Services](#)

[Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment](#)

[Health Care Declarations](#)

[ICD-9-CM, CPT, and HCPCS Reference Book Ordering](#)

[Immunizations Registry Help Desk](#)

[Medicaid ID Card Example](#)

[Medicaid Managed Care Services \(MMCS\)](#)

[Medicaid Reimbursement Unit Communications Hotline](#)

[Medicaid Tooth Numbering System](#)

[National Supplier Clearinghouse](#)

[Primary Care Physician \(PCP\) Enrollment Voice Response System](#)

[Provider Qualifications, Division of Behavioral Health Services](#)

[QSource of Arkansas](#)

[Select Optical](#)

[Standard Register](#)

[Table of Desirable Weights](#)

[ValueOptions](#)

[U.S. Government Printing Office](#)

[Vendor Performance Report](#)



Division of Medical Services
Program Development & Quality Assurance

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



TO: Arkansas Medicaid Health Care Providers – All Providers
DATE: January 1, 2013
SUBJECT: Provider Manual Update Transmittal SecV-8-12

Table with 4 columns: REMOVE Section, REMOVE Date, INSERT Section, INSERT Date. Rows include 500.000, DMS-0685-14, AAS-9565, and AAS-9506.

Explanation of Updates

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

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

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

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

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

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

QUARTERLY MONITORING FORM

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

TO:	DIVISION OF AGING AND ADULT SERVICES		
FROM:	Waiver Provider _____		
CLIENT	_____	SS# or Medicaid #	_____ County
First Quarter	Complete report forms first week in April	Date	_____
Second Quarter	Complete report forms first week in July	Date	_____
Third Quarter	Complete report forms first week in October	Date	_____
Fourth Quarter	Complete report forms first week in January	Date	_____
Please Complete the Following		circle one	Date
1.	Has the client entered the nursing home during this quarter?	yes no	_____
2.	Has the client entered the hospital this quarter?	yes no	_____
3.	Have services resumed?	yes no	_____
4.	Has the client expired during this quarter?	yes no	_____
5.	Has the client changed address during this quarter?	yes no	_____
	If yes, please indicate the new address below.		
6.	Services discontinued.	yes no	_____
	Reason _____		
7.	Other Changes _____		
8.	Comments _____		

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

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

