TOC Required

131.000 Charges that Are Not the Responsibility of the Beneficiary 9-1-0812-1-20

Except for cost sharing responsibilities outlined in Sections 133.000 – 135.000, a beneficiary is not liable for the following charges:

A. A claim or portion of a claim denied for lack of medical necessity.

B. Charges in excess of the Medicaid maximum allowable rate.

C. A claim or portion of a claim denied due to provider error.

D. A claim or portion of a claim denied because of errors made by DMS or the Arkansas Medicaid fiscal agent.

E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.

F. A claim or portion of a claim denied because a provider failed to obtain prior, concurrent, or retroactive authorization for a service.

G. A claim or portion of a claim denied because the claim did not meet Electronic Visit Verification (EVV) requirements (see 145.000).

GH. The difference between the beneficiary Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.

HI. Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service. Medicaid beneficiaries are not responsible for deductibles, co-payments, or coinsurance amounts to the extent that such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid payment is zero. The beneficiary is responsible for paying applicable Medicaid cost share amounts.

IJ. The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is billed, the individual must be refunded the full amount of his or her payment for the covered service(s). If it is agreeable with the individual, these funds may be credited against unpaid non-covered services and Medicaid cost-sharing amounts that are the responsibility of the beneficiary.

The beneficiary may not be billed for the completion and submission of a Medicaid claim form.

Exception: Medicaid does not cover the deductible, co-payments, or other cost share amounts levied to Medicare Part D drugs.

145.000 Electronic Visit Verification (EVV) for In-Home Personal Care, Attendant Care, and Respite-Services

MARK-UP

145.100 Legal Basis and Scope of EVV Requirement 12-1-20

In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) is implementing an electronic visit verification (EVV) system for in-home personal care services (PCS), attendant care, and respite services paid by Medicaid.

An EVV system is a telephone-, computer-, or other technology-based system under which visits conducted as part of personal care services or home health care services are electronically verified with respect to:

1. The type of service(s) performed;
2. The individual receiving the service(s);
3. The date of the service(s);
4. The location of service delivery;
5. The individual providing the service(s); and
6. The time the service(s) begins and ends.

The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that clients receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid PCS, attendant care, and respite care provided during an in-home visit under the Medicaid State Plan, the Provider-Led Arkansas Shared Savings Entity (PASSE), the ARChoices Medicaid §1915(c) Home and Community-Based Services Waiver, or under any self-direction plan.

PCS, attendant care, and respite services provided to more than one person throughout a shift in 24-hour residential settings are not subject to the EVV requirement because they do not involve an “in home” visit. This includes without limitation PCS, attendant care, and respite services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

PCS, attendant care or respite services provided to a student in a public school is not subject to the EVV requirement because it does not involve an “in-home” visit.

Additional information regarding EVV is available from the DHS EVV Vendor. **View or print the DHS EVV Vendor contact information.**

145.200 EVV Participation Requirements 12-1-20

To submit a claim for any service that is subject to the EVV requirement or pay based upon a self-directed plan of care subject to the EVV requirement, a provider must:

1. Submit and maintain on file with both DHS Provider Enrollment and the DHS EVV Vendor a contact e-mail address for the provider. The e-mail address must be one that is active and is controlled and regularly checked by the provider. The e-mail address must be a business address that is unique to the provider and must not be an employee’s personal e-mail address or other shared address. The e-mail address submitted by a provider to DHS Provider Enrollment will be the e-mail address used by the DHS EVV Vendor to create the provider’s account to access the EVV system;
2. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every caregiver employed or contracted by the provider to furnish care for which Medicaid PCS, attendant care, or respite care claims may be submitted;

MARK-UP

3. Submit, with every claim for a service subject to the EVV requirement, the PIN for the caregiver providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID#;

4. Use an EVV system that documents and verifies every in-home visit resulting in a claim for reimbursement. A provider must use the EVV system furnished by the DHS EVV Vendor or a third-party EVV system that has been certified by the DHS EVV Vendor;

5. Require caregivers employed or contracted by the provider to use EVV for all in-home Medicaid-paid PCS, attendant care, or respite care, and train the caregivers on the use of the provider's chosen EVV system;

6. If the provider uses the DHS EVV system, register the provider's caregivers with the EVV system. By registering a caregiver with the DHS EVV system, the provider is attesting that all applicable requirements, including without limitation training requirements, have been satisfied for that caregiver. A caregiver who is excluded or debarred from participation in Medicaid under any state or federal law is not eligible to register with the DHS EVV system;

7. Create and maintain documentation to justify any manual modifications, adjustments, or exceptions made by the provider in the EVV system after a caregiver has entered or failed to enter any required information;

8. Comply with EVV requirements established by the Centers for Medicare & Medicaid Services (CMS);

9. Comply with applicable federal and state laws regarding confidentiality of information about clients receiving services; and

10. Ensure that DHS may review documentation generated by an EVV system or obtain a copy of that documentation at no charge.

145.300 EVV Claims Requirements 12-1-20

EVV is required for the following procedure codes and modifiers when the Place of Service is coded as the beneficiary's home (POS code 12):

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) Beneficiary Under 21
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older
S5125	U2	Agency Attendant Care Traditional
S5150		Respite Care – In-Home

A claim for any of these procedure codes and modifiers may be rejected or denied, or subject to recoupment, if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

1. The data submitted in the claim;

2. The data recorded by EVV for the claimed service;

3. The data in the approved prior authorization or plan of care applicable to the claimed service; or

4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

A claim for any of these procedure codes and modifiers is subject to the EVV requirement regardless of how the claim is submitted, including third-party EVV vendors, through a PASSE claims system, or through a self-direction plan.

For PCS delivered in a beneficiary's home, it is a fraudulent billing practice to list any Place of Service (POS) code other than POS code 12, unless the Provider Manual or other Rule explicitly permits the use of a different POS code.

The EVV Requirement also applies to any equivalent services provided to a beneficiary through the IndependentChoices program, or any other self-direction program made available under the state plan or ARChoices. Such equivalent services may be rejected or denied if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

1. The data submitted in the claim;
2. The data recorded by EVV for the claimed service;
3. The data in the approved prior authorization or plan of care applicable to the claimed service; or
4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

145.400 Third Party EVV System Requirements 12-1-20

A third-party EVV system procured and chosen by a provider or Managed Care Organization (MCO) or self-directed services vendor must be certified by the DHS EVV Vendor as meeting the following requirements:

1. The provider must submit a written attestation that the third-party EVV system meets or exceeds all applicable CMS and DHS requirements. Certification of a third-party EVV system is valid only so long as the system continues to meet or exceed all applicable CMS and DHS requirements;
2. The DHS EVV Vendor must certify that the third-party EVV system has the technical capabilities to receive and transmit all EVV data in a way that is compatible with the DHS EVV system; and
3. The third-party EVV system must timely collect and submit to the DHS EVV Vendor all data required for EVV verification of a claim, including without limitation:
   a. The procedure code and modifier for the service(s) delivered, and the specific ADL/IADL task(s) performed by the caregiver during the visit;
   b. Identifying information for the beneficiary, including without limitation the beneficiary's Medicaid identification number;
   c. The date of the service(s);
   d. The location where the service(s) were delivered;
   e. Identifying information for the agency and the individual caregiver providing the service(s), including without limitation a Practitioner Identification Number (PIN) as assigned by DHS for the individual caregiver who is listed as the rendering provider;
   f. Universal Time Code (UTC) for the time the service(s) begins and ends; and
   g. EVV capture method (including without limitation telephony, GPS, or fixed visit) and corresponding validation data (including without limitation phone number, coordinates, or encryption key); and
4. By including a caregiver in any EVV data submitted to the DHS EVV Vendor, the provider is attesting that all applicable requirements, including without limitation training requirements and background checks, have been satisfied for that caregiver. Claims made for services performed by a caregiver who is excluded or debarred from participation in Medicaid may be denied or rejected and are subject to recoupment.

MARK-UP