

SECTION II - HOME HEALTH

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200.000 HOME HEALTH GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Home Health Providers

1-1-19

Home Health providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. Only home health agencies licensed to operate in Arkansas may participate in the Arkansas Medicaid Home Health Program.

- B. A provider participating in the Arkansas Medicaid Home Health Program must be currently licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.
- C. A provider participating in the Arkansas Medicaid Home Health Program must be currently certified by the Arkansas Home Health State Survey Agency as a participant in the Title XVIII (Medicare) Program.
- D. Providers participating in the Arkansas Medicaid Home Health Program must maintain documentation of current licensure and certification in their Medicaid provider enrollment files.
- E. The following individuals employed or contracted with a home health provider must comply with criminal background checks and central registry checks as required by law currently codified at Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.:
 - 1. Owners;
 - 2. Principals;
 - 3. Operators;
 - 4. Employees; and,
 - 5. Applicants (prior to the extension of a job offer)

Central registry checks under this section must include the:

- 1. Child Maltreatment Central Registry;
- 2. Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and,
- 3. Certified Nursing Assistant/Employment Clearance Registry

Enrolled providers must submit copies of license and certification renewals to the Provider Enrollment Unit, Division of Medical Services (DMS), within thirty (30) days of the issuance of those documents. [View or print Provider Enrollment Unit contact information.](#)

201.010 **Enrollment Procedures for Arkansas Medicaid Home Health Providers** **11-1-09**

Class A Home Health Agency providers applying to enroll in the Arkansas Medicaid Home Health Program must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as submit the following documents to be eligible to participate in the Arkansas Medicaid Program:

- A. A copy of the agency's current Class A Home Health Agency license, issued by the Division of Health Facility Services, Arkansas Department of Health.
- B. A copy of the agency's current Title XVIII (Medicare) certification, issued by the Arkansas Home Health State Survey Agency.

202.000 **Beneficiary Freedom of Choice** **6-1-04**

- A. A Medicaid-eligible beneficiary has freedom of choice among Arkansas Medicaid-enrolled home health providers.
- B. Home health services may be furnished only by written consent of the beneficiary or the beneficiary's representative. The beneficiary's representative must be an individual who has legal guardianship of the beneficiary's person or whom the court has designated as the beneficiary's representative by the court pursuant to competency proceedings.

- C. The home health agency must allow the beneficiary or the beneficiary's representative to participate in the treatment planning.
- D. The home health agency must advise the beneficiary or the beneficiary's representative of changes in the beneficiary's treatment before the changes take place.
- E. The home health agency must advise the beneficiary or the beneficiary's representative regarding advance directives.

203.000 **Home Health and the Primary Care Physician (PCP) Case Management Program (ConnectCare)** **7-1-17**

- A. Home health care requires a PCP referral except in the following circumstances:
 - 1. Medicaid does not require Medicare beneficiaries to enroll with PCPs; therefore, a PCP referral is not required for home health services for Medicare/Medicaid dual-eligibles.
 - 2. Obstetrician/gynecologists may authorize and direct medically-necessary home health care for postpartum complications without obtaining a PCP referral.
- B. A PCP may refer a beneficiary to a specific home health agency only if he or she ensures the beneficiary's freedom of choice by naming at least one alternative agency.
 - 1. PCPs, authorized attending physicians and home health agencies must maintain all required PCP referral documentation in the beneficiary's clinical records.
 - 2. PCP referrals must be renewed when specified by the PCP or every 60 days, whichever period is shorter.
- C. PCP referral is not required to revise a plan of care during a period covered by a current referral, but the agency must forward copies of the signed and dated assessment and the revision to the PCP.

204.000 **Authorized Attending Physician** **6-1-04**

In this provider manual the term "authorized attending physician" means:

- A. An attending physician to whom the PCP has referred the patient,
- B. The attending physician of a patient who is not required to enroll with a PCP or
- C. An obstetrician/gynecologist directing a home health plan of care for a Medicaid-eligible patient with postpartum complications.

205.000 **Record Retention Requirements** **11-1-09**

The record retention requirements in Section 140.000 apply to the home health records of beneficiaries of all ages. Special documentation and record retention requirements apply to beneficiaries under the age of 21. See Sections 206.000 and 218.000 for those additional requirements.

206.000 **Documentation of Services** **7-1-17**

Home Health providers must maintain the following records for patients of all ages; see Section 218.000 for additional documentation guidelines regarding physical therapy for patients under the age of 21. Additional information regarding documentation of services is located in Section 140.000 of this manual.

- A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans when applicable.
- B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.
- C. Signed and dated documentation of pro re nata (PRN) visits, which must include the following:
 - 1. The medical justification for each such unscheduled visit.
 - 2. The patient's vital signs and symptoms.
 - 3. The observations of and measures taken by agency staff and reported to the physician.
 - 4. The physician's comments, observations and instructions.
- D. Verification, by means of physician or approved non-physician practitioner documentation, that there was a face-to-face encounter with the beneficiary that meets the following requirements:
 - 1. For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or within 30 days after the start of services.
 - 2. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.
 - 3. The face-to-face encounter may be conducted by one of the following practitioners:
 - a. The primary care physician.
 - b. A nurse practitioner working in collaboration with the primary care physician.
 - c. A certified nurse midwife by the scope of practice.
 - d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid physician policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.
 - e. For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.
 - 4. The allowed non-physician practitioner performing the face-to-face encounter must communicate the clinical findings of that face-to-face to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
 - 5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician ordering the services must:
 - a. Document the face-to-face encounter, which is related to the primary reason the patient requires home health services, occurred within the required timeframes prior to the start of home health services.
 - b. Must indicate the practitioner who conducted the encounter and the date of the encounter.
 - 6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter.

- E. No payment may be made for medical equipment, supplies or appliances to the extent that a face-to-face encounter requirement would qualify as a durable medical equipment (DME) claim under the Medicare program unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in (D) 3 of this section with the exception of the nurse midwives.
- F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications, in each patient's medical records.
- G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.
- H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.
- I. The registered nurse's (or physical therapist's when applicable) notes from supervisory visits.

210.000 PROGRAM COVERAGE

211.000 Scope

10-13-03

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical and nursing needs can be met with part-time or intermittent care furnished by the home health agency in the patient's place of residence.

Part-time or intermittent care is periodic care for a few hours a day one or more times a week. In some cases, a plan of care may require services at intervals less frequent than weekly. Registered professional nurses and licensed practical nurses provide skilled care. A home health aide under the supervision of a registered professional nurse may furnish incidental personal care in conjunction with the patient care duties assigned by the registered nurse in accordance with an authorized plan of care. Physical therapy may be provided by a qualified physical therapist or by a physical therapy assistant under the supervision of a qualified physical therapist. A plan of care may require only home health aide services or physical therapy, or both, without requiring skilled nursing visits, but the home health aide services may not be only personal care.

Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)

211.100 Plan of Care Review

7-1-17

- A. All home health services are at the direction of the patient's PCP or authorized attending physician.
- B. The physician, in consultation with the patient and professional staff, is responsible for establishing the plan of care, specifying the type(s), frequency and duration of services.
- C. Medicaid requires the PCP or authorized attending physician to review the patient's plan of care as often as necessary to address changes in the patient's condition, but no less often than every 60 days.
 - 1. The physician establishes the start date of each new, renewed or revised plan of care. A "renewed" plan of care is a plan of care that has been reviewed in accordance with the 60-day requirement and has been authorized by the PCP or

authorized attending physician to continue, either with or without revision. A “revised” plan of care is a plan of care developed in response to a change in the patient’s condition that necessitates prompt review by the physician and reassessment by the case nurse.

2. The PCP or authorized attending physician must have performed a comprehensive (see Physician’s Common Procedural Terminology for guidelines regarding comprehensive evaluation and management procedures) physical examination with medical history or history update within the 12 months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.

211.200 Program Criteria for Home Health Services

7-1-17

- A. A Medicaid beneficiary is eligible for home health services only if he or she has had a comprehensive physical examination and a medical history or history update by his or her PCP or authorized attending physician within the twelve months preceding the beginning date of a new plan of care, the first date of service in an extended benefit period or the beginning date of service in a revised or renewed plan of care.
- B. The appropriateness of home health services is determined by the beneficiary’s PCP or authorized attending physician.
 1. An individual’s PCP or authorized attending physician determines whether the patient needs home health services, the scope and frequency of those services and the duration of the services.
 2. The PCP or authorized attending physician is responsible for coordination of the patient’s care, both in-home and outside the home.
- C. Some examples of individuals for whom home health services may be suitable are those who need the following:
 1. Specialized nursing procedures with regard to catheters or feeding tubes.
 2. Detailed instructions regarding self-care or diet.
 3. Rehabilitative services administered by a physical therapist.
- D. Some beneficiaries may require home health services of very short duration while they or their caregiver receive training enabling them to provide for particular medical needs with little or no assistance from the home health agency.
- E. Some individuals may need only intermittent monitoring or skilled care. When an individual’s skilled care is so infrequent that more than 60 days elapse between services, that individual requires a new assessment and a new plan of care for each episode of care, unless the physician documents that the interval without such care is no detriment and appropriate to the treatment of the beneficiary’s illness or injury.

211.300 Home Health Place of Service

7-1-17

Home health services may be provided in any normal setting in which normal life activities take place, other than a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound. The single exception to this policy permits Medicaid to reimburse a home health agency for providing nursing services to an ICF/IID resident on a short-term basis if the only alternative to home health services is inpatient admission to a hospital or a skilled nursing facility. Medicaid supplies, equipment and appliances suitable for use may be provided in any setting in which normal life activities take place.

212.000**Coverage****11-1-06**

Home health in the Arkansas Medicaid Program, when authorized by the client's PCP or authorized attending physician in accordance with the regulations set forth in this manual, comprises skilled nursing services (including home IV therapy), home health aide services, physical therapy, certain injections, disposable medical supplies and diapers and underpads.

- A. Skilled nursing services of Arkansas state-licensed, registered professional nurses and licensed practical nurses, as defined in the State Nurse Practice Act and this provider manual, are covered.
 - 1. Home IV Therapy is a skilled service, included in the coverage of LPN or RN home health visits.
 - a. The necessary supplies for home IV therapy may be furnished by the home health agency or by a Medicaid Prosthetics Program provider.
 - b. Drugs and biologicals are obtained through the Medicaid Pharmacy Program.
 - 2. Administration of Epogen is a skilled service that is covered separately from the nursing services included in a home visit.
- B. Home health aide services under the supervision of a registered professional nurse are covered. Aides must have current Title XVIII (Medicare) certification, whether the aide is an employee of a home health agency or is working under an arrangement with a home health agency.
- C. Physical therapy furnished by or under the supervision of a qualified, certified physical therapist is covered. Physical therapy assistants must meet or exceed Title XVIII (Medicare) requirements for physical therapy assistants employed by or working under an arrangement with a home health agency.
- D. Disposable medical supplies suitable for use in the home are covered.
- E. Diapers and underpads for incontinence attributable to conditions other than infancy are covered.

212.100**Skilled Nursing Services****10-13-03**

A home health agency furnishes skilled nursing services by or under the supervision of a registered nurse and in accordance with an individualized plan of care. The duties of registered nurses and licensed practical nurses are the same duties as required by the Title XVIII (Medicare) Program.

212.110**Duties of the Registered Nurse****10-13-03**

The registered nurse makes the initial assessment visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions, furnishes those services requiring substantial and specialized nursing skills, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.

212.120**Duties of the Licensed Practical Nurse****10-13-03**

The licensed practical nurse furnishes services in accordance with agency policies, prepares clinical and progress notes, assists the physician and registered nurse in performing specialized

procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the patient in learning appropriate self-care techniques.

212.130 Venipuncture and Catheterization for the Collection of Specimen 10-13-03

Venipuncture and catheterization for collection of specimen are excluded from the eligibility criteria for part-time or intermittent skilled nursing services under the home health benefit. If venipuncture and/or catheterization for the purpose of obtaining a sample are the only skilled services needed by the patient, that individual does not qualify for skilled nursing services in the Home Health Program.

212.140 Epoetin Alpha (Epogen) Injections 10-13-03

Administration of Epogen is a skilled nursing service that is covered separately from LPN and RN home health visits.

212.141 Epogen Injections for Renal Failure 10-13-03

Arkansas Medicaid covers the administration of Epogen injections to home health clients with acute or chronic renal failure when prescribed by the client's PCP or authorized attending physician.

The patient obtains the Epogen by prescription through the Medicaid Pharmacy Program. The prescriptions count toward the patient's monthly prescription benefit limit. Administration of the injections and the disposable supplies required are covered through the Home Health Program.

212.142 Administration of Epoetin Alpha Injections 10-13-03

Epogen is covered by Medicaid for patients of any age with anemia associated with rheumatoid arthritis, sideroblastic anemia, anemia associated with multiple myeloma, anemia associated with B-cell malignancies, myelodysplastic anemia and chemotherapy induced anemia.

212.150 Intravenous Therapy in a Patient's Home (Home IV Therapy) 7-1-17

Home IV therapy is a skilled nursing service that is included in coverage of LPN and RN home health visits. Home IV therapy is available to a Medicaid-eligible individual who is stabilized on a course of treatment and requires continued IV therapies in the home for several days or weeks. Medicaid requirements for establishing and maintaining home IV therapy are:

- A. A Medicaid-eligible individual may qualify for home IV therapy only if he or she has had a face-to-face encounter with their physician or the allowed non-physician practitioner as prescribed in 206.000 (D).
- B. The registered nurse employed by the Home Health provider must assess the patient and the patient's need for home IV therapy.
- C. The PCP or authorized attending physician, in consultation with the Home Health provider, establishes and authorizes a home health plan of care that includes the physician's instructions for IV therapy.
- D. The physician prescribes the IV drug(s).
 1. Prescriptions for IV drugs are subject to applicable Medicaid Pharmacy program policy and Medicaid program benefit limits.
 2. The client, the client's representative or the Home Health provider may obtain the drug(s) under the client's prescription drug benefit.

3. The pharmacy bills Medicaid or the patient, in accordance with Medicaid program policy, for the IV drugs.
- E. The plan of care must include the following:
1. Details regarding the patient training that will occur, describing the type, the amount and the frequency of self-care the patient will learn and perform.
 2. Realistic training goals.
 3. The projected date by which skilled nursing care will end or decrease because the client will be capable of self-care or of a designated portion of her or his self-care.
 - a. The registered nurse must visit and reassess the client before the projected date that the complete or partial self-care is to commence.
 - b. The home health agency in consultation with the PCP or authorized attending physician must terminate or revise the plan of care, basing its determination on the degree of self-care of which the client has become capable.
- F. The Home Health provider or a provider enrolled in the Arkansas Medicaid Prosthetics program may furnish the IV therapy supplies. Regardless of the source of the supplies, the Home Health provider is responsible for the deployment and management of the IV therapy supplies and for the documentation of their medical deployment and management.
- G. The Home Health provider must report the patient's status to the PCP or authorized attending physician in accordance with the physician's prescribed schedule in the plan of care.
- H. Nursing care in conjunction with IV therapy is in accordance with a home health plan of care, even if IV therapy is the only skilled service required and whether or not the client is receiving other home health services.

212.200**Home Health Aide Services****10-13-03**

- A. Home health aides employed by, or working under an arrangement with, home health agencies must meet the certification requirements and personnel standards of the Title XVIII (Medicare) Program.
- B. Home health aides perform medically necessary medical services that do not require the training of a nurse, but which require more training than that required of a personal care aide.
- C. Home health aides may provide personal care for their clients in conjunction with the medical services they provide if the following conditions are met:
 1. The home health plan of care and the home health aide's written instructions must specify both the medical services and the personal care services the aide is to provide and
 2. The home health plan of care must stipulate the type, frequency and duration of each medical and personal care service.
 - a. Individuals requiring only personal care are not eligible for home health services.
 - b. If personal care tasks and activities are the only services a home health plan of care requires of a home health aide, that portion of the client's care may be covered by Medicaid only through the Personal Care Program, under a personal care service plan.

212.300**Physical Therapy in the Home Health Program**

212.301 A Qualified Physical Therapist in the Home Health Program 11-1-06

- A. A qualified physical therapist must be a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association, as required by federal regulations at 42 CFR § 440.110(a)(2)(i).
- B. A qualified physical therapist must be licensed to practice as a physical therapist in Arkansas, with proof of the qualified physical therapist's current Arkansas licensure on file with the home health agency.

212.302 A Qualified Physical Therapy Assistant in the Home Health Program 11-1-06

- A. A qualified physical therapy assistant must have at least a bachelor's degree or college-level associate degree in physical therapy approved by the American Physical Therapy Association.
- B. A qualified physical therapy assistant must be licensed by the Arkansas State Board of Physical Therapy, with proof of the qualified physical therapist assistant's current state license on file with the home health agency.
- C. A qualified physical therapy assistant must be under the supervision (as defined by the Arkansas State Board of Physical Therapy and in Section 212.320 of this manual) of a qualified physical therapist.

212.310 Home Health Physical Therapy Coverage 11-1-06

Medically necessary physical therapy is covered in the Home Health Program for all ages under the following conditions.

- A. There must be a reasonable expectation that the intervention will result in clinically discernible functional gain(s) or will prevent a worsening of the condition.
- B. The physical therapy treatment plan must be Included in a home health plan of care.
- C. The therapy must be performed by a qualified physical therapist or by a qualified physical therapist assistant under the supervision of a qualified physical therapist.

212.311 Physical Therapy as the Sole Home Health Service 11-1-06

When the PCP or authorized attending physician prescribes medically necessary home health physical therapy and no other home health service, the following guidelines apply.

- A. The physical therapy treatment plan serves as the home health plan of care.
- B. The qualified physical therapist (but not a qualified physical therapist assistant) may make the required initial and subsequent patient assessments and perform the duties that would otherwise be those of the registered nurse.
- C. The PCP or authorized attending physician must authorize the treatment plan before physical therapy may begin. See Section 216.500 for conditions under which services may begin upon the physician's oral authorization.
- D. The PCP or authorized attending physician must review the treatment plan at the intervals required for home health plans of care.

- E. A comprehensive physical examination, with a complete history or history update, by the PCP or authorized attending physician is required within the twelve months preceding the start date of a new, renewed or revised physical therapy treatment plan.

212.312 Physical Therapy as a Component of a Home Health Plan of Care 4-16-12

- A. When the PCP or authorized attending physician prescribes medically necessary home health physical therapy as a component of a home health plan of care, the physical therapy treatment plan must be incorporated into the home health plan of care.
- B. Home health physical therapy for beneficiaries under the age of 21 is subject to additional documentation requirements; see Sections 218.000 through 218.100 of this manual and Section 214.320 of the Occupational, Physical, Speech Therapy Services Manual for more information.

212.320 Physical Therapist Supervision of Physical Therapy Assistants 6-1-04

- A. When a physical therapy assistant provides a beneficiary's home health physical therapy, the supervising qualified physical therapist must be readily available by telephone during the entire time the assistant is providing physical therapy.
- B. The supervising qualified physical therapist must review, sign and date, at least once every 30 days, the physical therapist assistant's case notes for each patient.

212.330 Qualified Physical Therapist Direction of Unlicensed Physical Therapy Students 11-1-06

Physical therapy services carried out by an unlicensed therapy student may be covered only when the following requirements are met.

- A. Physical therapy carried out by an unlicensed student must be under the direction of a qualified physical therapist, and the direction must be such that the qualified therapist is considered to be providing the physical therapy.
- B. To qualify as the performing provider, the qualified therapist must be present and engaged in observing and supervising the student during the entire physical therapy encounter.

213.000 Benefit Limits and Benefit Extensions

213.100 Home Health Visit Benefit Limit 6-1-04

The Arkansas Medicaid Program benefit limit for medically necessary home health visits is 50 visits per state fiscal year (SFY, July 1 through June 30) per beneficiary.

- A. The annual benefit limit is 50 home health visits by a registered nurse, a licensed practical nurse, a home health aide or a combination of the three.
- B. Visits made on a pro re nata (PRN or "as needed") basis are not exempt from this benefit limit; they count toward the beneficiary's 50 visits per SFY.
- C. Benefit extensions are available. See Section 213.510.

213.200 Physical Therapy Services Benefits 1-1-21

Refer to the [Occupational, Physical, and Speech-Language Therapy Manual](#) for medically necessary home health physical therapy visits that a beneficiary may receive.

- A. Home health physical therapy must be prescribed by the beneficiary's PCP or authorized attending physician and established on a current home health plan of care.
- B. Home health physical therapy for beneficiaries under the age of 21 is subject to additional documentation requirements; see Sections 218.000 through 218.100 of this manual and Section 214.320 of the [Occupational, Physical, Speech-Language Therapy Services Manual](#) for more information.

213.300 Medical Supplies Benefit Limit

10-15-09

The Arkansas Medicaid Program reimburses home health providers and prosthetics providers for medically necessary medical supplies up to a maximum of \$250.00 per month per Medicaid-eligible beneficiary. Medical supply expenditures through both the Home Health Program and the Prosthetics Program are combined to calculate the total monthly expenditure under the medical supplies benefit.

Extension of the medical supplies benefit is available to beneficiaries under the age of 21 in the Child Health Services (EPSDT) Program. See Section 213.500.

The following items are not subject to the \$250.00 per month benefit limit, but are limited to a specified daily number or amount:

Thick-It, per 8 oz. can. 1 unit = 1 can. Maximum = 4 units per date of service.

Stocking (Jobst)*. 1 unit = 1 stocking. Maximum = 2 units per date of service.

***NOTE: Stocking must be prior authorized. See Section 220.000 for prior authorization procedures.**

NOTE: For billing and documentation purposes, the date of service for medical supplies and diapers is the date of delivery.

213.400 Diaper and Underpads Benefit Limit

10-15-09

Diapers and underpads are covered by the Arkansas Medicaid Program but are benefit limited and must be medically necessary.

A. Medical Necessity

Diaper services must be medically necessary and the medical condition that prohibits the ability to potty train must be documented. Only patients with a medical condition that results in incontinence of the bladder and/or bowel may receive diapers through the Home Health and Prosthetics Programs. This coverage does not apply to infants who would be in diapers regardless of their medical condition. Medicaid does not cover underpads or diapers for beneficiaries under the age of 3 years.

B. Benefit Limit

The benefit limit for diapers and underpads is \$130.00 per month, per beneficiary, for diapers of any size and underpads. The benefit limit applies to any diaper or underpad, or any combination, whether provided through the Prosthetics Program, the Home Health Program or both. The limit on diapers and underpads is separate from the limit established for home health and durable medical equipment (DME) medical supplies.

The benefit may be extended with proper documentation.

C. Extension of Benefits for Diapers and Underpads

To obtain an extension of benefits for diapers and underpads, the following information must be submitted to the DMS Utilization Review. [View or print the DMS Utilization Review contact information.](#)

1. A completed Medicaid Form DMS-699, titled Request for Extension of Benefits for the requested time period prior to the delivery of the product. [View or print form DMS-699.](#)
2. Documentation supported by the medical record substantiating the medical necessity of an extension of benefits, including the prescription(s) for all prescribed incontinence products.

213.500 Benefit Extensions

11-1-05

Extensions of benefits are considered only for beneficiaries who have had a face-to-face evaluation and management (E&M) visit with their PCP or authorized attending physician within the twelve months preceding the beginning date of the requested extension.

- A. Benefit extensions are allowed for medically necessary home health skilled nursing visits and home health aide visits for beneficiaries of all ages.
- B. Benefit extensions for medically necessary medical supplies are allowed only for beneficiaries under the age of 21 in the Child Health Services (EPSDT) Program.
- C. Benefit extensions are allowed for medically necessary diapers and underpads for beneficiaries aged 3 and older.

213.510 Benefit Extension Request Procedures

10-15-09

- A. Submit requests for extensions of home health benefits to the Utilization Review Section. [View or print the Division of Medical Services UR/Home Health Extensions contact information.](#)
- B. A benefit extension request does not establish timely filing with respect to the one-year deadline for filing Medicaid claims.
 1. Only a clean claim establishes timely filing.
 2. See Section III of this manual for timely filing requirements.
- C. Minimum requirements for benefit extension requests are as follows.
 1. A completed benefit extension request form
 - a. For beneficiaries age 3 years and older, use form DMS-699.
 2. Medical records substantiating medical necessity for additional services/supplies
 3. The current home health plan of care, signed and dated by the PCP or authorized attending physician
 4. The supervising registered nurse's case narrative
 5. The medical record of a comprehensive physical examination with history or history update within the twelve months preceding the beginning service date of the extended benefit period

213.511 Benefit Extension Approvals

11-1-05

- A. When a benefit extension is approved, a benefit extension control number is assigned.

- B. The approval notification letter lists the procedure codes approved for benefit extension, the approved dates or date-of-service range, the number of units of service authorized and the benefit extension control number.

213.512 **Benefit Extension Denials and Reconsideration Requests** **6-1-25**

When an extension is denied or only partially approved, the provider and the beneficiary receive notification letters.

213.513 **Administrative Reconsideration and Appeals** **6-1-25**

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

213.514 **Continuation of Services Pending the Outcome of an Appeal** **6-1-25**

Refer to Section 161.500 of Section I of this Manual regarding the continuation of services pending the outcome of an appeal.

213.515 **Reserved** **6-1-25**

214.000 **Exclusions** **10-13-03**

The following items are not covered as home health services:

- A. Custodial care,
- B. Personal care services only,
- C. Occupational therapy, speech pathology services, audiology services, respiratory therapy,
- D. Personal comfort items, durable medical equipment, oxygen, orthotic appliances or prosthetic devices,
- E. Drugs provided through the Arkansas Medicaid prescription drug program,
- F. Laboratory services,
- G. Social worker visits and
- H. Registered nurse or licensed practical nurse visits the sole purpose of which are catheterization or venipuncture for the collection of specimen.

215.000 **Reserved** **6-1-25**

216.000 **Assessment, Care Plan Development and Physician Authorization** **10-13-03**

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical and nursing needs can be met adequately by the agency in the patient's place of residence.

- A. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)
1. The PCP's or authorized attending physician's orders or referrals do not constitute a plan of care.
 2. Before home health services may be covered by Medicaid, all the following must occur:
 - a. A registered nurse must assess the patient in the patient's place of residence.
 - b. The registered nurse and the PCP or authorized attending physician, in consultation with the patient or the patient's representative and appropriate staff, must establish a plan of care.
 - c. The PCP or authorized attending physician must authorize the plan of care by signing it and dating the signature.
- B. Plan Of Care Requirements
1. The plan of care developed in consultation with the agency staff must address:
 - a. All pertinent diagnoses, including mental status,
 - b. Types of services required,
 - c. Frequency of visits,
 - d. Prognosis,
 - e. Rehabilitation potential of physical therapy, if applicable,
 - f. Functional limitations,
 - g. Activities permitted,
 - h. Nutritional requirements,
 - i. Medications and treatments,
 - j. Any safety measures to protect against injury,
 - k. Goals or expected outcomes,
 - l. Conditions that may warrant *pro re nata* (PRN) visits,
 - m. The number of PRN visits that will initiate a reassessment and
 - n. Instructions for timely discharge or referral.
 2. Instructions in the plan of care for therapy services must include:
 - a. The specific procedures and modalities to be used and
 - b. Their amount, frequency, and duration.
 3. The qualified physical therapist and other agency personnel (as well as the patient if the patient so desires) participate in developing the plan of care.

216.100**Start Date of the Plan of Care****10-13-03**

- A. Care provided before the date of the physician's signature authorizing the plan of care is not covered. See part B of Section 216.500 for the sole exception to this requirement.
- B. The start date of care is the date specified in the plan of care or the date of the physician's signature, whichever occurs later; however, the date of the physician's signature may be after the start date of care when all conditions at Section 216.500, part B, are met. New, renewed and revised plans of care must specify the year, month and date of the first service to be provided under that plan of care.

216.200 Pro Re Nata (PRN) Services

10-13-03

Within the plan of care the PCP or authorized attending physician must identify the conditions under which *pro re nata* (“as needed” or “PRN”) services may occur and the number of PRN visits that may occur before the home health agency must initiate reassessment and develop a revised plan of care. PRN visits for any reason must be documented and reported to the PCP or authorized attending physician.

216.300 New, Renewed and Revised Plans of Care

10-13-03

- A. A new plan of care is one developed for a client:
1. Who has never had home health care,
 2. Who has not had any home health care for 63 or more days preceding the beginning date of the current episode of care (except in a case of intermittent care in which the physician has documented that the interval without such care is appropriate to the treatment of the beneficiary’s illness or injury),
 3. Whose home health care has been interrupted by an inpatient stay of any length in a hospital or nursing facility or
 4. Who has transferred her or his care from another home health provider.
- B. A renewed plan of care is a plan of care that the PCP or authorized attending physician has reviewed at least once in accordance with the 62-day requirement and has authorized the home health provider to continue with the plan of care unchanged or with changes in type, frequency or duration of service.
1. The case nurse and the PCP or authorized attending physician consult regularly and make frequent, sometimes daily or hourly, modifications in the care furnished a particular client.
 2. The case nurse must commit all such modifications to writing, sign and date them and insert them in or attach them to the case record. Only a registered nurse may commit a physician’s oral orders to writing and authorize their execution pending the physician’s signature.
 3. Rewriting the plan of care to incorporate each of these daily or interim modifications as they occur is not a requirement, because some occur only once or are temporary measures.
 4. The notes regarding the modified services must, however, become part of the clinical record in such a manner that the persons delivering the care will always be certain that they are following the most recent instructions and that they are logging, noting or reporting the exact services they furnish.
 5. At the next regular physician review (i.e., the review conducted in accordance with the 62-day review requirement) of the plan of care, those interim modifications that have become part of the regular routine must be incorporated into the renewed plan of care.
- C. A revised plan of care is one developed and established when, between the regular physician reviews of the plan of care, changes occur in the patient’s medical condition which necessitate rewriting the plan of care, as opposed to inserting an order or two into the case record.
1. In such an event the home health agency’s registered nurse must perform an in-home patient assessment, consult with the physician and appropriate staff to revise

the plan of care and obtain the physician's dated authorization of the revised plan of care.

2. A revised plan of care is developed and established in the same manner as is a new plan of care. The difference between a revised plan of care and a new plan of care is that a revised plan of care is for a patient whose care is ongoing but whose condition has suddenly and significantly changed.
3. Physician authorization requirements for revised plans of care are identical to physician authorization requirements for a new plan of care. Revised plans of care must indicate the date of the reassessment and must specify the revised plan's start date.

216.400 Plan of Care Termination

10-13-03

A plan of care is deemed terminated if 62 days pass in which a home health client does not receive a home health service. If a client is receiving care that is so infrequent that more than 62 days elapse between services, that individual will require a new assessment and a new plan of care for each episode of care, unless the PCP or authorized attending physician documents that the interval without such care is appropriate to the treatment of the client's illness or injury.

216.500 Requirement for Physician Authorization of the Care Plan

10-13-03

- A. Care provided before the date of the physician's signature authorizing the plan of care is not covered.
 1. Initial, revised or renewed home health plans of care must be signed and dated by the PCP or authorized attending physician before the agency may implement the plan.
 2. The physician signature requirement may be modified under certain specified circumstances, which follow.
- B. In order that needed care may not be delayed, the home health agency may begin furnishing services after the assessment and plan of care are completed, with the PCP's or authorized attending physician's oral authorization only if the following conditions are met and thoroughly documented:
 1. The physician issues the oral authorization to the registered nurse coordinating the development of the plan of care. (The oral authorization may be issued to the qualified physical therapist if physical therapy is the only home health service the client is to receive.)
 2. The registered nurse (or qualified physical therapist when applicable) receiving the oral authorization documents the oral authorization within the plan of care and in the patient's clinical record, including the physician's name and title, and the registered nurse (or qualified physical therapist when applicable) signs and dates the notation.
 3. The PCP or authorized attending physician signs and dates the home health agency's file copy of the plan of care within fourteen working days after the oral authorization. To expedite this process, the physician may fax the signed and dated document to the home health agency.
 4. The physician and the home health agency must each retain a copy of the signed and dated plan of care in their office file of the patient's medical records. At least one of the two copies must contain the physician's original signature.

216.600 Plan of Care Requirement for Participants in the Home and Community Based Waiver Programs

1-1-19

When developing plans of care for individuals who participate in home and community based services (HCBS) waiver programs, such as ARChoices in Homecare, providers must communicate with the registered nurse employed by the Department of Human Services (DHS RN) in charge of the case, in order to coordinate the home health plan of care and the HCBS plan of care. See Section I for additional information and requirements.

217.000 Registered Nurse Supervision of Home Health Aide Services 7-1-17

- A. The supervising registered nurse must issue written instructions to the home health aide.
 - 1. The instructions must specify the aide's specific duties at each visit.
 - 2. The aide must note that he or she has performed each task and note, with written justification of the omission, which tasks he or she did not perform.
- B. If a beneficiary is receiving home health aide services only, the registered nurse must visit the beneficiary at least once every 60 days to assess his or her condition and to evaluate the quality of service provided by the home health aide.
- C. If a beneficiary is receiving only physical therapy and home health aide services, with no skilled nursing services, either the registered nurse or the qualified physical therapist may make this required supervisory visit.

218.000 Additional Documentation Requirements for Physical Therapy Patients Under the Age of 21 1-1-09

- A. Providers must maintain documentation supporting medical necessity of physical therapy services. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.
 - 1. Medicaid requires a referral from the primary care physician (PCP) or a referral from the authorized attending physician if the beneficiary is exempt from mandatory PCP enrollment. All therapy services for beneficiaries under the age of 21 require referrals be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21" form DMS-640.
 - 2. Medicaid requires a written prescription for physical therapy signed and dated by the PCP or the authorized attending physician. For beneficiaries under age 21 the prescription must be completed on a separate DMS-640 form. [View or print form DMS-640](#). After the initial referral using the form DMS-640 and initial prescription, utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640 for beneficiaries under age 21. Instructions for completion of form DMS-640 are located on the back of the form. Providers of therapy services are responsible for obtaining renewed PCP referrals every six months even if the prescription for therapy is for one year. A prescription for therapy services is valid for the length of time specified by the prescribing physician, up to one year.
 - a. The PCP or authorized attending physician must complete and sign form DMS-640/prescription with their original signature. Medicaid will accept an electronic signature provided that it is in compliance with Arkansas Code 25-31-103. A rubber stamp signature is not acceptable.
 - b. The PCP or authorized attending physician must maintain the original prescription (form DMS-640) in the beneficiary's medical record.
 - c. The home health provider must maintain a copy of the original prescription form in the patient's medical record.
 - 3. Medicaid requires that a physical therapy treatment plan be developed, signed and dated by a qualified physical therapist and/or a physician. The plan must include

individualized goals that are functional, measurable and specific to the beneficiary's medical needs.

- B. Documentation must include, when applicable, an Individualized Family Services Plan (IFSP) established in accordance with part C of the Individuals with Disabilities Education Act (IDEA).
- C. Medicaid requires, when applicable, an Individualized Education Program (IEP) established in accordance with part B of IDEA.
- D. Documentation must be supported by therapy evaluation reports to substantiate medical necessity, signed or initialed and dated progress notes and any related correspondence.
- E. Documentation must include discharge notes and summary.

218.100

Retrospective Review of Physical Therapy for Beneficiaries Under the Age of 21

7-1-20

A. Medical Necessity

Physical therapy services must be medically necessary for the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical therapist; and
3. There must be a reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluation and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed, including:

1. Date of evaluation;
2. Child's name and date of birth;
3. Diagnosis specific to therapy;
4. Background information including pertinent medical history and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

$$7 \text{ months} - [(40 \text{ weeks}) - 28 \text{ weeks}] / 4 \text{ weeks}]$$

$$7 \text{ months} - [(12) / 4 \text{ weeks}]$$

$$7 \text{ months} - [3]$$

$$4 \text{ months};$$

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores, or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services;
 6. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
 7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone, or a narrative of the child's functional mobility skills (strengths and weaknesses);
 8. An interpretation of the results of the evaluation including recommendations for therapy/minutes per week;
 9. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
 10. Signature and credentials of the therapist performing the evaluation.
- C. Interpretation and Eligibility: Ages Birth to 21
1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
 2. Tests must be age appropriate for the child being tested.
 3. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
 4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one (1) subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
 5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing, or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
 6. The Mental Measurement Yearbook (MMY) is the standard reference to determine reliability/validity. Refer to the "Accepted Tests" section for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
 7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a deficit limits function.
 8. Muscle Tone: Modified Ashworth Scale.
 9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
 10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
 11. Children (birth to age twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
 12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.

13. Children (age three (3) to twenty-one (21)) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical Therapy Services

The frequency, intensity, and duration of physical therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring, or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name;
2. Date of service;
3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of entry with a full signature and credentials; and
8. Graduate students must have the supervising physical therapist co-sign progress notes.

218.200 Accepted Tests for Physical Therapy

3-15-12

To view a current list of accepted tests for Physical Therapy, refer to Section 214.320 of the Occupational, Physical, Speech Therapy Services manual.

219.000 Service Logging by Electronic Media

7-1-05

- A. Nurses, home health aides, physical therapists and physical therapy assistants may log the times that they begin and end services, as well as the services themselves, by electronic media, such as telephony.
- B. Electronic signatures, as permitted under Arkansas law and as defined in Section IV of this manual, are allowed in the Home Health Program.

- C. All Arkansas Medicaid documentation requirements must be met, regardless of documentation media.

219.100 Electronic Signatures

7-1-05

Medicaid will accept electronic signatures provided the electronic signature complies with the Arkansas Code § 25-31-103 et seq.

220.000 PRIOR AUTHORIZATION**221.000 Request for Prior Authorization and Prescription (Form DMS-679A) for the Gradient Compression Stocking (Jobst Stocking)**

10-15-09

Gradient Compression Stockings (Jobst stocking), requires prior authorization for beneficiaries of all ages. [View or print form DMS-679A and instructions for completion](#). See Sections 213.300 and 242.150 for more information regarding the Jobst stocking.

The primary care physician or authorized attending physician must sign the form DMS-679A. The physician's signature must be an original, not a stamp.

When a request is approved, a prior authorization control number is assigned and entered on the copy of the Medical Equipment Request for Prior Authorization and Prescription Form (form DMS-679A) and is returned to the provider within 30 working days of receipt of the prior authorization request.

Prior authorization is limited to a maximum of six months of service.

222.000 Denial of Prior Authorization Request

10-15-09

The Utilization Review Section reviews requests for prior authorization of medical supplies. The effective date of prior authorization is the date on which the item is to be delivered to the patient, as indicated in Field 13 of the form DMS-679A, or the day following the end date of the previous prior authorization of the supplies, whichever comes second.

Denied requests are returned to the provider and the beneficiary within 30 working days of receipt of the request. The reason for the denial is included.

223.000 Reserved

6-1-25

230.000 REIMBURSEMENT**231.000 Method of Reimbursement**

11-1-06

- A. Medicaid reimbursement for home health services is by fee schedule, at the lesser of the amount billed or the Title XIX (Medicaid) maximum fee.
- B. The Arkansas Medicaid Program reimburses providers for administration of covered injections by fee schedule, at the lesser of the amount billed or the Title XIX (Medicaid) maximum fee.
- C. The Arkansas Medicaid Program reimburses providers by the visit for nursing services, aide services and physical therapy.
- D. The Arkansas Medicaid Program reimburses providers by fee schedule, at the lesser of the amount billed or the Title XIX (Medicaid) maximum fee per covered item, for disposable medical supplies, diapers and underpads.

231.010 Fee Schedules

12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov/> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

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

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

232.000 Rate Appeal Process

10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES**241.000 Introduction to Billing**

7-1-20

Home Health providers who submit paper claims must use the CMS-1450 claim form, which also is known as the UB-04 claim form.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of every Arkansas Medicaid provider manual contains information about available electronic claim options.

241.100 Electronic Visit Verification (EVV)

1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding home health services.

242.000 CMS-1450 Billing Procedures for Home Health Services**242.100 Home Health Procedure Codes****6-1-04**

Some HCPCS procedure codes in these sections may require modifiers that are not listed here. Until you receive official Medicaid correspondence regarding necessary modifiers, contact the Provider Assistance Center for the most up-to-date modifier requirements.

242.110 Home Health Visits**2-1-22**

[View or print the procedure codes for Home Health services.](#)

242.120 Home Health Physical Therapy**2-1-22**

[View or print the procedure codes for Home Health services.](#)

242.130 Specimen Collection**2-1-22**

[View or print the procedure codes for Home Health services.](#)

- A. Venipuncture (drawing blood to obtain a blood sample) and catheterization to collect urine specimens are excluded from the eligibility criteria for intermittent skilled nursing services under the home health benefit.
- B. When venipuncture to obtain a blood sample or catheterization to collect a urine specimen is the only skilled service that is needed by the patient, that individual does not qualify for skilled services.

242.140 Injections**242.141 Epogen Injections for Renal Failure****2-1-22**

[View or print the procedure codes for Home Health services.](#)

242.142 Epogen Injections for Diagnosis other than Renal Failure**2-1-22**

[View or print the procedure codes for Home Health services.](#)

242.143 National Drug Codes (NDCs)**1-1-23**

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

- A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor website](#).

A complete listing of “**Covered Labelers**” is located on the website. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*. For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA-assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 1 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the “5-4-2” format.

Diagram 1

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 2 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 2

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233

01111 456 71

01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

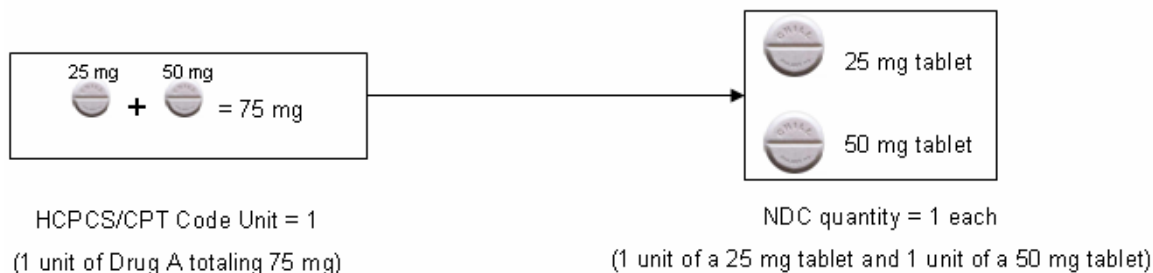
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

C. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

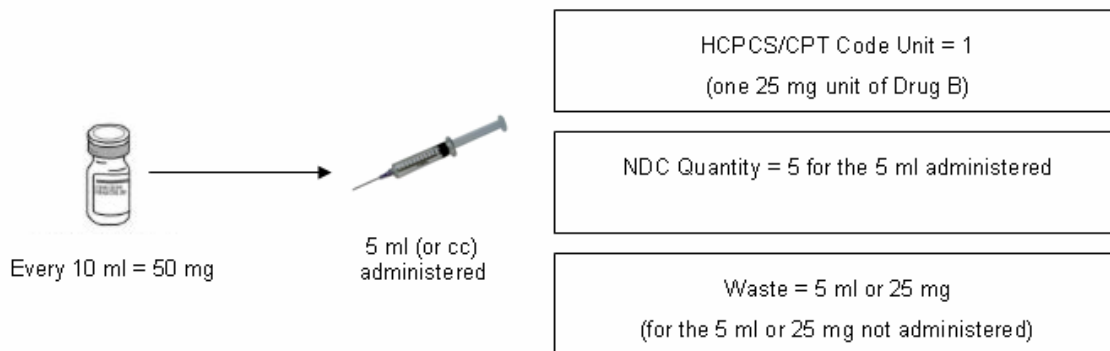
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example, whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 3.

Diagram 3



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. For billing wastage, see bullets D (Electronic Claims Filing) and E (Paper Claims Filing) below.

Diagram 4



D. Electronic Claims Filing 837I (Outpatient)

Providers are instructed to bill as follows:

- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 4 or more NDCs for same procedure – submit via paper claim
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

E. Paper Claims Filing CMS-1450 (UB-04)

Providers are instructed to bill as follows:

- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 4 or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation

- JW = Drug wastage

Diagram 5

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	N4 12345678912 UN 1.00	Z1234 KP	01/01/22	1	2500		
0636	N4 01111222233 UN 1.00	Z1234 KQ	01/01/22	1	2500		
0636	N4 44444455506 ML 3.00	Z1234 KQ	01/01/22	3	7500		
0636	N4 44444455506 ML 2.00	Z1234 JW	01/01/22	2	5000		

F. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

G. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

242.144 Billing of Multi-Use and Single-Use Vials

1-1-23

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

[View or print the procedure codes for Home Health services.](#)

- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.
 - Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.

3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 242.143 for additional information regarding National Drug Code (NDC) billing.

242.150 Home Health Medical Supplies

8-1-24

The following Health Care Procedural Coding System (HCPCS) codes must be used when billing the Arkansas Medicaid Program for medical supplies. Providers must use the current HCPCS Book for code descriptions.

[View or print the procedure codes for Home Health services.](#)

Listed below are medical supplies that require special billing or need prior authorization. These items are listed with the HCPCS codes and require modifiers. The asterisk denotes these items and the required modifiers.

- A. *Home Blood Glucose Supplies – Available to all beneficiaries
- B. **Gradient Compression Stocking (Jobst Stocking), All Ages

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. Before supplying the items, the Jobst stocking must be prior authorized by AFMC. [View or print form DMS-679A and instructions for completion.](#) Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stocking and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy.

Code must be manually priced.

Code requires a prior authorization (PA). See Section 221.000.

Code requires prior authorization (PA); see Section 221.000. Code is manually priced and is covered for beneficiaries ages 0-20 years of age.

- C. ***Food Thickeners, All Ages

Food thickeners, including “Thick-it”, “Simple Thick”, “Thick and Easy” and “Thick and Clear” are not subjected to the medical supply benefit limit.

The modifier **NU** must be used with the code found in this section and when food thickeners are administered enterally, the modifier “**BA**” must be used in conjunction with the code.

When food thickeners are billed, total units are to be calculated to the nearest full ounce. Partial units may be rounded up. When a date span is billed, the product cannot be billed until the end date of the span has elapsed.

The maximum number of units allowed for food thickeners is 16 units per date of service.

The following HCPCS codes usage must match the Arkansas Medicaid code description and use of modifier(s).

242.160 Incontinence Supplies

2-1-22

Codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

[View or print the procedure codes for Home Health services.](#)

Reimbursement is based on a per unit basis with one unit equaling one item (diaper or underpad). When billing for these services that are benefit limited to a dollar amount per month, providers must bill according to the calendar month.

Providers must not span calendar months when billing for diapers and/or underpads. The date of delivery is the date of service. Provider may not bill “from” and “through” dates of services.

242.200 Place of Service and Type of Service Codes

10-13-03

Not applicable to this program.

242.300 Billing Instructions – Paper Only

11-1-17

Medicaid does not supply providers with Uniform Billing claim forms. Numerous vendors sell CMS-1450 (UB-04 forms.) [View a sample CMS-1450 \(UB-04\) claim form.](#)

Complete Arkansas Medicaid program claims in accordance with the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid’s billing instructions, requirements and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding CMS-1450 (UB-04.) [View or print NUBC contact information.](#)

The committee develops, maintains and distributes to its subscribers the UB-04 Data Specifications Manual and periodic updates. The NUBC is also a vendor of CMS-1450 (UB-04) claim forms.

Following are Arkansas Medicaid’s instructions for completing, in conjunction with the UB-04 Data Specifications Manual (UB-04 Manual), a CMS-1450 (UB-04) claim form.

Please forward the original of the completed form to the Claims Department. [View or print the Claims Department contact information.](#) One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

242.310 Completion of the CMS-1450 Claim Form

9-1-14

Field #	Field name	Description
1.	(blank)	Enter the provider’s name, (physical address – service location) city, state, zip code and telephone number.

Field #	Field name	Description
2.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail.)
3a.	PAT CNTL #	The provider may use this optional field for accounting purposes. It appears on the RA beside the letters "MRN." Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	See the UB-04 manual. Four-digit code with a leading zero that indicates the type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	<p>Enter the covered beginning and ending service dates. Format: MMDDYY.</p> <p>To bill on a single claim for home health services occurring on multiple dates, enter the beginning and ending service dates in the FROM and THROUGH fields of this field.</p> <p>The dates in this locator must fall within the same fiscal year – the state's fiscal year and the home health agency's fiscal year. When a service-date span overlaps either fiscal-year end, submit 2 claims, with the first claim's THROUGH date on or before the fiscal-year end date and the second claim's FROM date on or after the first day of the new fiscal year.</p>
7.	Not used	Reserved for assignment by the NUBC.
8a.	PATIENT NAME	Enter the patient's last name and first name. Middle initial is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	Enter the patient's date of birth. Format: MMDDYYYY.
11.	SEX	Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	Not required.
13.	ADMISSION HR	Not required.
14.	ADMISSION TYPE	Not required.
15.	ADMISSION SRC	Not required.
16.	DHR	Not required.
17.	STAT	Not applicable.
18.- 28.	CONDITION CODES	Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.

Field #	Field name	Description
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.- 34.	OCCURRENCE CODES AND DATES	Required when applicable. See the UB-04 Manual.
35.- 36.	OCCURRENCE SPAN CODES AND DATES	See the UB-04 Manual.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	Not applicable.
a.	CODE	Not applicable.
	AMOUNT	Not applicable.
b.	CODE	Not applicable.
	AMOUNT	Not applicable.
40	VALUE CODES	Not applicable.
41.	VALUE CODES	Not applicable.
42.	REV CD	Not applicable.
43.	DESCRIPTION	Not required.
44.	HCPCS/RATE/HIPPS CODE	See this provider manual for procedure codes.
45.	SERV DATE	Enter a service date for each procedure code. Date format: MMDDYY.
46.	SERV UNITS	Comply with the UB-04 Manual's instructions.
47.	TOTAL CHARGES	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
48.	NON-COVERED CHARGES	Not applicable.
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Line A is required. See the UB-04 for additional regulations.
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	Required. See the UB-04 Manual.
53.	ASG BEN	Not required.
54.	PRIOR PAYMENTS	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 or ARKids First-B co-payments.

Field #	Field name	Description
55.	EST AMOUNT DUE	Situational. See the UB-04 Manual.
56.	NPI	Enter NPI of billing provider or enter the Medicaid ID.
57.	OTHER PRV ID	Not required.
58. A, B, C	INSURED'S NAME	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
59. A, B, C	P REL	Comply with the UB-04 Manual's instructions when applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	Enter the patient's Medicaid identification number on first line of field.
61. A, B, C	GROUP NAME	Using the plan name if the patient is insured by another payer or other payers, follow instructions for field 60.
62. A, B, C	INSURANCE GROUP NO	When applicable, follow instructions for fields 60 and 61.
63. A, B, C	TREATMENT AUTHORIZATION CODES	Enter any applicable prior authorization or benefit extension control number on line 63A.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.
65. A, B, C	EMPLOYER NAME	When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable).
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code "9" designating ICD-9-CM diagnosis required on claims. Qualifier Code "0" designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual's instructions on claims processing requirements.
67. A-H	(blank)	Enter the ICD-9-CM or ICD-10-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission or subsequently develop, and that have an effect on the treatment received, the medical supplies needed or the number and types of visits required. Fields are available for up to 8 codes.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Not required.
70.	PATIENT REASON DX	Not required. See the UB-04 Manual
71.	PPS CODE	Not required.
72.	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	Not used	Reserved for assignment by the NUBC.

Field #	Field name	Description
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not applicable
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI	Enter NPI of the primary attending physician or enter the Medicaid ID.
	QUAL	Not required.
	LAST	Enter the last name of the primary attending physician.
	FIRST	Enter the first name of the primary attending physician.
77.	OPERATING NPI	NPI not required.
	QUAL	Not applicable.
	LAST	Not applicable.
	FIRST	Not applicable.
78.	OTHER NPI	Enter NPI of the referring physician or enter the Medicaid ID.
	QUAL	Not required.
	LAST	Enter the referring physician's last name.
	FIRST	Enter the referring physician's first name.
79.	OTHER NPI/QUAL/LAST/FIRST	Not used.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

242.400 Special Billing Procedures

242.410 Billing for Home Health Services for Beneficiaries of Both Medicare and Medicaid 10-13-03

Medicare covers home health services only for beneficiaries who are confined to their homes and who require skilled care. Medicaid covers home health services for beneficiaries who may be able to leave their homes but require assistance to do so, and who may or may not need skilled care but who need short-term or intermittent care requiring skills more advanced than those of a personal care aide. Some dual-eligible beneficiaries who are not eligible for home health services under the Medicare Program are eligible for home health services under the Medicaid Program. Providers of home health services to those individuals must maintain in each client's file a copy of the **Advance Beneficiary Notice** from Medicare denying them coverage of home health services.

242.420 Completion of Form — Medicare/Medicaid Deductible And Coinsurance

11-1-09

See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover Claim procedures.

242.430 Medical Supplies and Diapers/Underpads

7-1-17

When billing for these services, which are benefit-limited to a maximum number of dollars per month, providers must bill according to the **calendar** month. **Providers may not span calendar months when billing for medical supplies and diapers and underpads.** The date of delivery is the date of service. Providers may not enter different dates for “from” and “through” dates of service.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and that are required to address an individual medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.