TOC required

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

145.100 Legal Basis and Scope of EVV Requirement 1-1-24

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, respite services, and home health 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:

A. The type of service(s) performed;

B. The individual receiving the service(s);

C. The date of the service(s);

D. The location of service delivery;

E. The individual providing the service(s); and

F. 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 beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid PCS, attendant care, respite care, and home health 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, respite services, and home health services provided to more than one (1) 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, respite services, and home health services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

PCS, attendant care, respite services, and home health services provided to a student in a public school are not subject to the EVV requirement because they do 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 1-1-24

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:

A. 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 an address that is active and is controlled and regularly checked by the provider. The e-mail address must be

Procedure Code	Modifier	Service Description
T1021		Home Health Aide Visit
S9131	UB	Home Health Physical Therapy by a Qualified Physical Therapy Assistant
S9131		Home Health Physical Therapy by a Qualified Licensed Physical Therapist

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:

A. The data submitted in the claim;

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

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

D. 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, attendant care, respite and Home Health services 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.

A. The EVV Requirement also applies to any equivalent services provided to a beneficiary through the Independent Choices 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 the plan of care that is 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.

TOC required

261.100 Electronic Visit Verification (EVV) 1-1-24

Refer to Provider Manual Section 1, General Policy, subsection 145.000 for EVV requirements regarding attendant care and respite care services.

TOC required

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.

TOC required

261.100 Electronic Visit Verification (EVV) 1-1-24

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

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Electronic Visit Verification (EVV) for Home Health Services

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

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes ☑ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☑ No ☐

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$(341,176)	General Revenue	$(782,500)
Federal Funds	$153,886	Federal Funds	$(593,568)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	-$ 187,289.00	Total	-$ 1,376,068.00

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ -341,176.00	$ -782,500.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☑

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

RULES SUBMITTED FOR REPEAL

Rule #1:

DDS Policy 1027 – Incident Reporting Procedural Guidelines-

Rule #2:

DDS Policy 1035 – Agency Definition of Disability/Eligibility for Services.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

Procedural Guidelines for DHS Policy 3002-I, Incident Reporting.

1. The employee(s) or volunteer(s) first having knowledge of a reportable incident shall immediately report to the on-site administrator (specific chain of reporting will be according to procedures developed at the program site).

2. The employee(s) or volunteer(s) utilizing Attachment #1 will immediately document the incident details and provide the form to the on-site administrator.

3. Within one (1) hour of determination of an applicable incident, the on-site administrator will make verbal/fax notification to the following individuals:

   A. DDS Director/Designee
   682-8665

   NOTIFY IN ALL INCIDENTS

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   B. DHS Advocate: Marsha Smith
   682-8650

   NOTIFY IN ALL INCIDENTS

   C. DDS Licensure
   682-8697

   NOTIFY IN ALL INCIDENTS IN COMMUNITY PROGRAMS

Replacement Notation: This procedural guideline replaces DDS Commissioner's Policy #1027 effective December 14, 1981 and January 8, 1987.

Effective Date: December 1, 1993 Sheet 1 of 4

References: DHS Policy 3002-I plus attachments.

Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council : November 4, 1993.

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

4. Additional notifications will be made to the following individuals/offices when specific incident(s) occur:

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X-Notification

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

Attachment 2 shall be utilized for documenting notification and made a part of incident/investigative files.

5. The on-site administrator will initiate and ensure prompt investigation, when required and unless otherwise directed by outside agencies (i.e., Law Enforcement, Coroner, State Medical Examiner, Prosecuting Attorney). Internal investigation will be conducted according to DDS Procedural Guidelines for Investigation if the incident is at a state operated institution/program.

6. The on-site administrator will be the primary point of contact with external sources unless otherwise determined.

7. The on-site administrator will submit a written report (summary to-date or final report) of the incident/investigation within three (3) days of the initial reporting to all those initially notified, and any external authority so requesting.

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8. The on-site administrator will submit a final report/investigative file of any reported incident, within time frames established by applicable Policy, depending on the specific incident. All final reports will be forwarded to the appropriate Supervisor. The DDS Director shall provide report copies to all those initially notified, External Authorities and/or others as necessary/requested.

9. The on-site administrator is responsible for the development of on-site procedures, in the absence of Departmental/Divisional Policy/Procedure, specific to the following items which comply with DHS Policy #3002-I and DDS Procedural Guidelines #1027 as well as those incidents not covered by #3002-I and #1027.

A. Unusual Client Deaths and/or Serious Injuries
B. Absence (Run-away) and Search Procedures
C. Criminal Activity
D. Maltreatment - Prevention, Reporting and Investigating
E. Natural Disasters (Emergency Preparedness)
F. Serious Accidents
G. Disruption of Service

Policy Type	Subject of Policy	Policy No.
Administrative	Incident Reporting Procedural Guidelines	1027

10. On-site procedures shall include but not necessarily be limited to the following:

A. Reporting/Notification requirements
B. Staff/Volunteer Responsibilities
C. Documentation
D. Training Requirements for Staff
E. Specific tasks/assignments (who does what, when) of staff
F. Applicability to DHS Policy #3002-I

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NOTIFICATION LISTING REQUIREMENTS PER INCIDENT						
FIRE DEPARTMENT						
X						
LOCAL LAW ENFORCEMENT		X		X	X	
STATE POLICE: 224-9370						
Chief Operator-Communications Center		X			X	X
LOCAL PROSECUTING ATTORNEY						
STATE MEDICAL EXAMINER		X				
227-5936						
COUNTY CORONER		X				
DEBBY NYE, CHIEF COUNSEL						
Office: 682-8934		X		X	X	X
X	X	X	X			
Home: 835-7282						
INDIVIDUAL UNDER 18						
(CHILD PROTECTIVE SERVICES)						
1-800-482-5964 or 324-9013/9016		X	X	X		
		X				

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and LOCAL DIVISION OF					
CHILDREN AND FAMILY SERVICES:	X	X	X		
INDIVIDUAL OVER 18					
(ADULT PROTECTIVE SERVICES)					
1-800-482-8049 or 682-2441	X	X	X		
OFFICE OF LONG TERM CARE	X	X	X	X	X
682-8487					
OFFICE OF EMERGENCY SERVICES					
Office:					
Home:					
ARKANSAS DEPARTMENT OF HEALTH					
661-2316					
DIRECTOR, COTTAGE LIFE/TEAM LEADER	X	X	X		
NURSING SERVICES ADMIN.	X	X	X		
SOCIAL SERVICES	X	X	X	X	
DIRECTOR, HAB & TRAINING	X				
PHYSICIAN	X	X	X		
PARENT/GUARDIAN (NEXT OF KIN)	X	X	X	X	
OTHER:					
OTHER:					

X = Notification

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NOTIFICATION LISTING	REQUIREMENTS PER INCIDENT						
DDS Director							
Office: 682-8665	X	X	X	X	X	X	X
Pearl Herman, DHS Advocate							
Office: 682-8650	X	X	X	X	X	X	X
DDS LICENSURE INVOLVING COMMUNITY Office: 682-8697	NOTIFY IN ALL INSTANCES PROGRAMS						
PHYSICIAN/HOSPITAL							
FIRE DEPARTMENT						X	
LOCAL LAW ENFORCEMENT	X		X	X			
STATE POLICE: 324-9370							
Chief Operator-Communications Center	X			X	X		
LOCAL PROSECUTING ATTORNEY							
STATE MEDICAL EXAMINER	X						
227-5936							
COUNTY CORONER	X						
DEBBY NYE, CHIEF COUNSEL							
Office: 682-8934	X		X	X	X	X	X
Home: 835-7282							
INDIVIDUAL UNDER 18							
(CHILD PROTECTIVE SERVICES)							
1-800-482-5964 or 324-9013/9016	X	X	X				

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and LOCAL DIVISION OF							
CHILDREN AND FAMILY SERVICES:	X	X	X				
INDIVIDUAL OVER 18							
(ADULT PROTECTIVE SERVICES)							
1-800-482-8049 or 682-2441	X	X	X				
OFFICE OF LONG TERM CARE	X	X	X	X	X	X	X
682-8487							
OFFICE OF EMERGENCY SERVICES							
Office:						X	
Home:							
ARKANSAS DEPARTMENT OF HEALTH							X
661-2316							
DIRECTOR, COTTAGE LIFE/TEAM	X	X	X				
LEADER							
NURSING SERVICES ADMIN.	X	X	X				
SOCIAL SERVICE	X	X	X			X	X
DIRECTOR, HAB & TRAINING	X						
PHYSICIAN	X	X	X				
PARENT/GUARDIAN (NEXT OF KIN)	X	X	X			X	X
OTHER:							

X = Notification

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TIME NOTIFIED	COMMENTS AND NOTES

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ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	Agency Definition of Disability/Eligibility for Services	1035

1. Purpose. This policy has been prepared to set minimum parameters for determining eligibility to receive services from Developmental Disabilities Services (DDS).

2. Scope. All individuals and their families applying for services offered by DDS.

3. Definitions. For purposes of this policy, Primary Disability/Condition, Primary Diagnosis, and Other Disabilities are defined as follows:

   A. Primary Disability - That condition which renders the most serious impairment and/or condition which has the greatest impact on an individual's ability to function, as outlined in Arkansas Statute Ann. 20-48-101.

   B. Primary Diagnosis - A medical designation, determined by a physician, usually denoting etiology of disabling condition.

   C. Other Disabilities - Any condition(s) which accompanies the primary disability, and further hinders the development of an individual.

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4. Eligibility Criteria.

   A. Diagnosis of developmental disability under definition cited in Arkansas Code Ann. § 20-48-101.

      1) Is attributable to intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy or autism spectrum disorder.

         a. Intellectual Disability - As established by scores of intelligence which fall two or more standard deviations below the mean of a standardized test of intelligence administered by a legally qualified professional; Infants/Preschool, 0-5 years - developmental scales, administered by qualified personnel authorized in the manual accompanying the instrument used, which indicate impairment of general functioning similar to that of developmentally disabled persons;

         b. Cerebral Palsy - As established by the results of a medical examination provided by a licensed physician;

         c. Spina bifida – As established by the results of a medical examination provided by a licensed physician.

         d. Down syndrome – As established by the diagnosis of a licensed physician.

e. Epilepsy - As established by the results of a neurological and/or licensed physician;

f. Autism Spectrum Disorder - As established by the results of a team evaluation including at least a licensed physician and a licensed psychologist and a licensed Speech Pathologist;

NOTE: Each of these four conditions is sufficient for determination of eligibility independent of each other. This means that a person who is intellectually disabled does not have to have a diagnosis of autism spectrum disorder, epilepsy, spina bifida, down syndrome, or cerebral palsy. Conversely, a person who has autism spectrum disorder, cerebral palsy, epilepsy, spina bifida, or Down syndrome does not have to have an intellectual disability to receive services.

2) Is attributable to any other condition of a person found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with intellectual disability or requires treatment and services similar to those required for such persons. This determination must be based on the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

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a) In the case of individuals being evaluated for service, eligibility determination shall be based upon establishment of intelligence scores which fall two or more standard deviations below the mean of a standardized test of intelligence OR, is attributable to any other condition found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability, or requires treatment and services similar to those required for such persons.

b) Persons age 5 and over will be eligible for services if their I.Q. scores fall two or more standard deviations below the mean of a standardized test.

c) For persons ages 3 to 5, eligibility is based on an assessment that reflects functioning on a level two or more standard deviations from the mean in two or more areas as determined by a standardized test.

d.) For infants and toddlers 0-36 months, eligibility for DDS Services will be indicated by a 25% delay in two or more areas based on an assessment instrument which yields scores in months. The areas to be assessed include: cognition; communication; social/emotion; motor; and adaptive.

3) Is attributable to dyslexia resulting from intellectual disability, cerebral palsy, epilepsy spina bifida, Down syndrome or autism spectrum disorder as established by the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

NOTE: In the case of individuals being evaluated for service, eligibility shall be based upon their condition closely related to an intellectual disability by virtue of their adaptive behavior functioning.

B. The disability must originate prior to the date the person attains the age of twenty - two (22).

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NOTE: When age becomes a factor in eligibility determination under the Arkansas Law, such a case will be evaluated on its own merit as to whether the condition resulting from the disability was present before age twenty-two (22). In such cases, the determining authority will be the Assistant Director of Client Services and/or the Director for Developmental Disabilities Services.

Policy Type	Subject of Policy	Policy No.
Administrative	Agency Definition of Disability/Eligibility for Services	1035

C. The disability has continued or can be expected to continue indefinitely.

D. The disability constitutes a substantial handicap to the person's ability to function without appropriate support services including, but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment.

5. Services. Given the availability of funds and subject to budget restrictions, DDS will provide services to eligible persons.

6. Appeal. Should the individual and parent/guardian disagree with the decision made, they retain the right of appeal following DDS Policy #1076.

Replacement Notation: This policy replaces DDS Commissioner's Office Policy 1035, Eligibility for Services, effective June 29, 1981; May 10, 1982; and October 7, 1983 and DDS Deputy Director's Policy #1035, January 8, 1985, December 1, 1993.

REPEAL-EO 23-02

Effective Date:

Sheet 1 of 4

References: Arkansas Code Ann. 20-48-101, DDS Policy #1075, and DDS Policy #1020

Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council: January 16, 2018

Policy Type	Subject of Policy	Policy No.
Administrative	Agency Definition of Disability/Eligibility for Services	1035

ATTACHMENT 1
DDS Administrative Policy No. 1035 – Agency Definition of Disability
Eligibility for Services

1. Referral is to include a memorandum by DDS Counselor with reason(s) for referral, why DDS eligibility is not clear, what are the reasons for dispute, and the referring person's own recommendation.

2. Adaptive Behavior Scale (within the last year).

3. Current Medical status (within the last year).

4. Psychological evaluation (within the last year) if eligibility request is based on psychological reasons.

5. Results of special evaluations relevant to eligibility determination.

6. Documentation by Service Coordinator of client observation within the last three (3) months.

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7. Social History completed within the last 90 days by DDS Counselor.

8. The most recent Individual Education Plan if person is school age.

9. For individuals who are not school age, program plan of current or past services providers, if any.