ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Provider Billing for Services by a Family Member-AR PASSE-AD-1225	12/01/2022-10/31/2023

Policy Type
ADMINISTRATIVE

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject....2
B. Background....2
C. Definitions....2
D. Policy....3
E. Conditions of Coverage....5
F. Related Policies/Rules....5
G. Review/Revision History....5
H. References....5

A. Subject

Provider Billing for Services by a Family Member

B. Background

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. Individual state programs govern staff requirements and individuals eligible for reimbursement for services to beneficiaries of various Medicaid-eligible programs.

C. Definitions

- **AR Choices Services** - Home and community-based, outpatient services to prevent nursing home placement among ages 21 through 64 with a physical disability, requiring an intermediate level of care in a nursing facility, or 65 years of age or older requiring an intermediate level of care in a nursing facility.
- **Beneficiary (or Member)** - Person who meets Medicaid eligibility requirements, receives an identification card, and is eligible for Medicaid services.
- **Caregiver** - An individual who has responsibility for the protection, in-home care, or custody of a beneficiary as a result of assuming the responsibility by contract.
- **IndependentChoices** - Personal assistance services provided by caregivers who are recruited, interviewed, hired, and managed by the beneficiary or a designated representative.
- **Living Choices Assisted Living** - Home and community-based services waiver program for persons aged 21 and older with physical disabilities and eligible for nursing home admission at the intermediate level of care to live in his/her own home or in certain types of congregate settings.
- **Medical Necessity** - A service is “medically necessary” if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction and if there is no other equally effective, although more conservative or less costly, course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a “course of treatment” may include mere observation or, where appropriate, no treatment at all. The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental, inappropriate, or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary.
- **Person Centered Service Plan (PCSP)** - A written plan that provides information and support directing the process of care for a member to the maximum extent possible and enabling informed choices and decisions, reflecting services and supports to meet needs identified through an assessment of functional need, both

paid and unpaid, to achieve identified goals, and identifying the providers of those services and supports, including natural supports.

- **Personal Care Services** - Medically necessary services authorized by Department of Human Services (DHS) professional staff or designated contractor(s) and individually designed to assist beneficiaries with physical dependency needs.
- **Private Duty Nursing** - Medically necessary medical care services provided to a beneficiary by a registered nurse or licensed practical nurse under the direction of a physician in a place of residence, a Division of Developmental Disabilities Services (DDS) community provider facility, or a public school.

D. Policy

I. General Provisions:

A. All providers, including relatives, are required to meet all Arkansas provider certification requirements, including training requirements, and all Arkansas Medicaid enrollment requirements.

B. Services provided must be according to the beneficiary's PCSP and any established benefit limits for that specific service.

C. The provider on file with Arkansas Medicaid is the biller of services. The family member is an employee of that provider and must adhere to rules for billing services according to provider policies and procedures and Arkansas Medicaid certification and enrollment requirements.

II. Programs with specific provisions regarding family members employed by servicing providers:

A. ARChoices

1. All ARChoices services may be provided by a beneficiary's relative, unless stated otherwise in the ARChoices Provider Manual. A relative or family member is any person related to the beneficiary by virtue of blood, marriage, or adoption.
2. Travel time is not reimbursable if any other adult person accompanying (or driving) the participant is a family member and is reasonably able to assist the participant in transit if needed.
3. Respite Care - The purpose is to provide respite for unpaid caregivers. An individual living in the home with the beneficiary is not allowed to serve as a respite services provider for that beneficiary.
4. Reimbursement is not permitted for ARChoices services, including respite care, for the following:
    1. Beneficiary spouse,
    2. Legal guardian of the beneficiary, or
    3. Attorney-in-fact granted authority to direct the beneficiary's care.

B. IndependentChoices

1. Family members, other than those with legal responsibility to the beneficiary, may serve as personal assistants. A court appointed legal guardian, spouse, power of attorney or income payee may not serve as a caregiver/employee.
2. The Arkansas Medicaid program covers up to 14.75 hours per week (64 hours per calendar month) of State Plan Personal Care Services for participants

aged 21 years and older assessed as needing personal care. The hour limit does not apply to beneficiaries under age 21.

3. IndependentChoices follows the policy in the Arkansas Medicaid Personal Care Provider Manual in determining eligibility and level of assistance of personal care the ARChoices Provider Manual regarding attendant care services needed by the IndependentChoices participant.
4. A representative may be a legal guardian, other legally appointed representative, an income payee, family member, or friend. The representative may not be paid for this service and may not be an employee of the participant.

C. Living Choices Assisted Living

Living Choices attendant care services may be provided by a certified personal care aide who is not a legally responsible family member or legally responsible caregiver, including the following:

- A spouse,
- A legal guardian of the person, or
- An attorney-in-fact authorized to direct care for the beneficiary.

D. Personal Care Services

1. Personal care services are provided by a personal care aide primarily based on the assessed physical dependency need for "hands-on" services specific to the member's activities of daily living (ADL).
2. Personal care services are furnished to beneficiaries who are not inpatients or residents of a hospital, nursing facility, Level II assisted living facility, intermediate care facility for persons with intellectual disabilities, or institution for mental disease. Services are provided in the beneficiary's home, and at the State's option, in another location by an individual qualified to provide such services who is not a member of the beneficiary's family.
3. Travel time is not reimbursable if any other adult person accompanying (or driving) the beneficiary is a family member and is reasonably able to assist the beneficiary in transit if needed.
4. Reimbursement for personal care services is not permitted for the following:
   a. A beneficiary spouse,
   b. A minor's parent, stepparent, foster parent, or anyone acting as a minor's parent,
   c. Legal guardian of the beneficiary, or
   d. Attorney-in-fact granted authority to direct the beneficiary's care.

E. Private Duty Nursing Services

The following family members, or persons acting as family members, cannot provide care to a beneficiary through the Arkansas Medicaid Private Duty Nursing (PDN) program:

1. A spouse,
2. A minor's parent or anyone acting as a minor's parent,
3. A minor's guardian or anyone acting as a minor's guardian,
4. An adult's guardian or anyone acting as an adult's guardian, or
5. Anyone, regardless of relationship, who resides with the beneficiary.

E. Conditions of Coverage

Nonmedical community supports and services (NCSS) are available under federal authority in sections 1905, 1915(c), and/or 1915(i) and included in the PASSE program created under Arkansas Act 775. NCSS are provided with the intention to prevent or delay entry into an institutional setting or to assist or prepare an individual to leave an institutional setting. The service should assist the individual to live safely and successfully in his/her own home or in the community. NCSS must be rooted in specific member needs found identified through the Independent Assessment leading to placement in the PASSE and included within an individually created Person-Centered Service Plan (PCSP). NCSS should be reviewed and updated regularly through the care coordination and PCSP process. NCSS are not medical in nature but instead support pursuit of safe independent living and member goals clearly established in the member's PCSP.

F. Related Policies/Rules

Medical Necessity Determinations
Nonmedical Community Supports and Services

G. Review/Revision History

	DATE	ACTION
Date Issued	8/31/2022	New policy.
Date Revised		
Date Effective	12/01/2022	
Date Archived	10/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Arkansas Department of Human Services. ARChoices In Home Care Home and Community-Based 2176 Waiver Provider Manual, Sections I, II and IV. Retrieved July 28, 2022 from www.humanservices.ar.gov.
2. Arkansas Department of Human Services. IndependentChoices Provider Manual, Section 2. Retrieved August 2, 2022 from www.humanservices.ar.gov.
3. Arkansas Department of Human Services. Living Choices Assisted Living Provider Manual, Section 2. Retrieved August 2, 2022 from www.humanservices.ar.gov.
4. Arkansas Department of Human Services. Personal Care Provider Manual, Sections I, II, IV. Retrieved July 28, 2022 from www.humanservices.ar.gov.
5. Arkansas Department of Human Services. Private Duty Nursing Provider Manual, Section 2. Retrieved August 2, 2022 from www.humanservices.ar.gov.
6. Centers for Medicare and Medicaid Services (CMS). Retrieved August 2, 2022 from www.medicaid.gov.
7. Code of Federal Regulations. § 441.540 Person-centered service plan. (July 29, 2022). Retrieved August 2, 2022 from www.ecfr.gov.

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.