TOC required

141.000 Provider Enrollment 9-1-26

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided by the provider to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature and the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

In addition to the information in Section 140.000, Section II of each program's provider manual may contain supplemental provider type specific participation requirements. The provider enrollment functions for the Arkansas Medicaid Program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. Potential providers must complete all appropriate portions of a provider enrollment Application Packet to execute the provider contract. They must also submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the applicable provider type or discipline to be practiced and pay the application fee (if applicable). See Section 141.101 for Application Fees.

Potential providers can learn how to enroll on the **Provider Enrollment webpage** of the DMS website. Potential providers who are not required to pay application fees may also send the printed form to the Medicaid Provider Enrollment Unit. **View or print the Provider Enrollment contact information.**

All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. **View or print the provider enrollment and contract package (Application Packet).**

In addition to the submission of the Application Packet, the following forms are required and must be submitted to complete the enrollment process:

A. Medicaid Provider Contract (DMS-652)

B. PCP Agreement, if applicable (DMS-2608. See Section 171.000 for PCP requirements.)

C. EPSDT Agreement, if applicable (DMS-831. See Section 201.000 of the EPSDT provider manual for the EPSDT Agreement.)

D. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

E. Authorization for Electronic Funds Transfer (Automatic Deposit)

F. National Provider Identifier (if applicable) for health care providers as defined in 45 CFR § 160.103

The provider must provide identifying information including the following: name, specialty, date of birth, Social Security number, Federal taxpayer identification number, and the State license or certification number (if applicable). This information is required for the screening processes required by 42 CFR Subpart E.

Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

A. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

B. Change in Federal Employer Identification Number (FEIN) may require the completion of a new enrollment application

C. Authorization for Electronic Funds Transfer (Automatic Deposit)

D. Change in practice or specialty

E. Retirement or death of provider

F. Name Change Form

G. Change of Ownership Form (DMS-0688) (**View or print form DMS-0688 – Provider Change of Ownership Information Form.**)

H. Address/Email Change Form (DMS-673) (**View or print form DMS-673 – Address/Email Change Form.**) **NOTE:** An active email address is required.

I. Change in Ownership Control (5% or more) or Conviction of Crime (**View or print form DMS-675 – Ownership and Conviction Disclosure.**)

J. Disclosure of Significant Business Transactions (**View or print form DMS-689 – Disclosure of Significant Business Transactions.**)

When the provider has successfully met all requirements, the Medicaid Provider Enrollment Unit will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security Number or a Federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) if applicable.

The **National Provider Identifier (NPI)** is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Some entities do not qualify for NPIs. Specifically, any entity that does not meet the definition of a health care provider as defined in 45 CFR § 160.103 may not apply for an NPI.

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

145.100 Legal Basis and Scope of EVV Requirement 9-1-26

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

Personal care, attendant care, respite care, 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: personal care, attendant care, respite care, and home health services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

Personal care, attendant care, respite care, 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 State-sponsored EVV Vendor.

145.200 EVV Participation Requirements 9-1-26

To submit a claim or encounter for any service subject to the EVV requirement, a provider must:

A. Submit and maintain on file with both Arkansas Medicaid Provider Enrollment and the State-sponsored EVV Vendor the following:

1. A contact e-mail address for the provider agency/employer of record. 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 a business address that is unique to the provider and must not be an employee’s personal e-mail address or other shared address.

2. A contact e-mail address for the rendering provider (RN, LPN, PT, PTA, Home Health Aide, or caregiver). The e-mail address must be active and controlled and regularly checked by the rendering provider. The e-mail address must be unique to the rendering provider and must not be a shared address.

3. The e-mail addresses submitted by the provider to Arkansas Medicaid Provider Enrollment will be the e-mail addresses used by the State-sponsored EVV Vendor.

B. Submit to DHS an EVV Declaration Form, DMS-9654, identifying the agency’s chosen EVV vendor and resubmit with any vendor changes prior to implementation. Agencies choosing a vendor other than the State’s shall follow the process for third party EVV system certification outlined in Section 145.400 Third Party EVV System Requirements;

C. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every rendering provider or contracted by the provider to furnish care for which Medicaid personal care, attendant care, or respite care claims may be submitted;

D. Ensure the rendering provider is not excluded or debarred from participation in Medicaid under any state or federal law;

E. Submit, with every claim or encounter for a service subject to the EVV requirement, the PIN for the rendering provider providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID number;

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

G. Require rendering providers, employed or contracted by the provider, to use EVV for all in-home visits for Medicaid-paid personal care, attendant care, respite care, and home health care and to train the rendering providers on the use of the provider's chosen EVV system;

H. Ensure the rendering provider has met the providers' training requirements;

I. Use a mobile device application, an interactive voice response system (IVR/telephony) via the beneficiary's landline phone, or in some instances, an alternative verification device if approved by DHS, to capture valid EVV visits;

J. Submit EVV compliant (as detailed in §145.100 of this manual) visits. Edited and manually entered visits are not EVV compliant and should be entered only as a last resort. Providers submitting non-compliant visits that are more than ten percent (10%) of total visits over a three-month timeframe must submit a corrective action plan within fourteen (14) calendar days of written notice, to ensure compliance with EVV requirements. If providers continue to have subsequent instances with more than ten percent (10%) of their total visits being non-compliant after the corrective action plan is implemented, additional sanctions as listed in Section 150.000 may be imposed;

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

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

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

N. Provide DHS upon its request, documentation generated by an EVV system or obtain a copy of that documentation at no charge.

The sanctions listed in Section 150.000 Administrative Remedies and Sanctions may be imposed if the provider does not meet the EVV requirements.

For the most up to date information, providers can visit the **Arkansas DHS EVV website**.

145.300 EVV Claims Requirements 9-1-26

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

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) Beneficiary Under 21
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older

Procedure Code	Modifier	Service Description
S5125	U2	Agency Attendant Care Traditional
S5150		Respite Care – In-Home
T1021	TD	Home Health RN Visit, per visit
T1021	TE	Home Health LPN Visit, per visit
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 personal care, attendant care, respite care, 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.

145.400 Third Party EVV System Requirements 9-1-26

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

A. The provider must attest that the third-party EVV system meets or exceeds all applicable CMS and DHS requirements using a **DMS-9655 Third-Party EVV System Attestation form**. Certification of a third-party EVV system is valid only so long as the system continues to meet or exceed all applicable CMS and DHS requirements;

B. The State-sponsored EVV Vendor must certify that the third-party EVV system has the technical capabilities to receive and transmit all EVV data in a way that is compatible with the DHS EVV system; and

C The third-party EVV system must timely collect and submit to the State-sponsored EVV Vendor all data required for EVV verification of a claim, including without limitation:

1. The procedure code and modifier for the service(s) delivered, and the specific ADL/IADL task(s) performed by the rendering provider during the visit;

2. Identifying information for the beneficiary, including without limitation the beneficiary's Medicaid identification number;
3. The date of the service(s);
4. The location where the service(s) were delivered;
5. Identifying information for the agency and the individual rendering provider providing the service(s), including without limitation a Practitioner Identification Number (PIN) as assigned by DHS for the individual who is listed as the rendering provider;
6. Universal Time Code (UTC) for the time the service(s) begins and ends; and
7. EVV capture method (including without limitation mobile device application, interactive voice response system (IVR/telephony), or approved alternative verification device) and corresponding validation data (including without limitation phone number, GPS coordinates, or encryption key). For vendors offering use of an alternative verification device, these must be reviewed and approved by DHS to be considered a valid EVV capture method.

D. By including a caregiver in any EVV data submitted to the State-sponsored EVV Vendor, the provider is attesting that all applicable requirements, including without limitation training requirements and background checks, have been satisfied for that rendering provider. Claims made for services performed by a rendering provider who is excluded or debarred from participation in Medicaid may be denied or rejected and are subject to recoupment.

E. DHS needs to be able to identify services received at home versus in the community. Therefore, all EVV systems must have the capability to identify and report visits taking place outside of a geofence as determined by DHS. The geofence does not prevent services from being provided.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. 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 EVV for In-home Personal Care, Attendant Care, Respite Care, and Home Health

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	$0	General Revenue	$0
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

(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**
$	$

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.