Arkansas Department of Health and Human Services

Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers – DDS Alternative Community Services (ACS)**

DATE: **May 1, 2006**

SUBJECT: **Provider Manual Update Transmittal # 60**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.200	10-13-03	201.200	5-1-06
211.000	10-1-05	211.000	5-1-06
213.100	10-1-05	213.100	5-1-06
214.000	10-1-05	214.000	5-1-06
223.000	10-1-05	223.000	5-1-06
230.210	10-13-03	230.210	5-1-06
230.211	10-1-05	230.211	5-1-06
230.212	10-13-03	230.212	5-1-06
230.213	10-1-05	230.213	5-1-06
230.223	10-13-03	230.223	5-1-06
230.410	10-13-03	230.410	5-1-06
230.420	10-13-03	230.420	5-1-06
230.430	10-13-03	—	—
251.000	10-13-03	251.000	5-1-06
262.000	10-13-03	262.000	5-1-06
272.100	12-5-05	272.100	5-1-06

Explanation of Updates

Section 201.200 has been included to clarify a portion of the organized health care delivery system.

Section 211.000 has been included to for grammatical changes regarding the scope of the waiver. The change does not affect policy.

Section 213.100 has been included to clarify policy regarding payment of supportive living services.

Section 214.000 has been included to clarify that the DDS approved activities shown may include others that are not listed in the section.

Section 223.000 has been included to revise the phrase “levels of service” to “service levels”. Language has been added to inform providers of the process involved when there are service gaps of thirty (30) consecutive days.

Section 230.210 has been included to revise the heading and language in the body of the section from “Levels of Service” to “Service Levels.”

Section 230.211 has been included to revise the heading of the section to “Pervasive Service Level” and to include documentation needed in requesting the pervasive service level. Language in the body of the section has also been revised to reflect the name change.

Section 230.212 has been included to revise the heading and language in the body of the section from “Extensive Level of Care” to “Extensive Service Level”.

Section 230.213 has been included to revise the heading and language in the body of the section from “Limited Level of Care” to “Limited Service Level”.

Section 230.223 has been included to revise the phrase “level of care” to “service level”.

Section 230.410 has been included to indicate revisions in the policy required in MAPS.

Section 230.420 has been included to revise the heading title from “MAPS for Individual, Group and Self-Directed Option Categories” to “MAPS” Policy has also been revised.

Section 230.430 titled “MAPS for Moderate and Minimum Supported Living and Supplemental Support Services Categories” has been deleted.

Section 251.000 has been included to change the title of the agency from Department of Human Services to the Department of Health and Human Services.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

Section 262.000 has been included to change the title of the agency from the Department of Human Services to the Department of Health and Human Services.

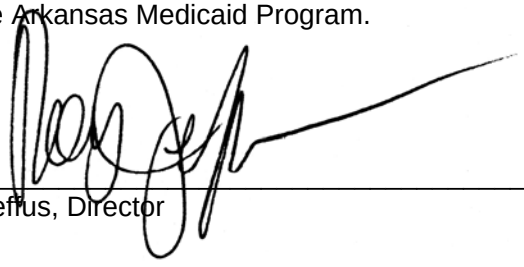
Section 272.100 has been included to change the description of procedure code T2020, UA from “community experiences” to “Supplemental Support Services”.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

SECTION II - DDS ALTERNATIVE COMMUNITY SERVICES (ACS) WAIVER

CONTENTS

201.200 Organized Health Care Delivery System Provider 5-1-06

The DDS Alternative Community Services (ACS) Waiver allows a provider who is licensed and certified as a DDS ACS case manager or a DDS ACS supportive living services provider to enroll in the Arkansas Medicaid Program as a DDS ACS organized health care delivery system (OHCDS) provider.

As long as the OHCDS provides at least one waiver service, an OHCDS provider may provide any other DDS ACS Waiver service via a sub-contract with an entity qualified to furnish the service.

The OHCDS provider furnishes the services as the individual's provider of choice as described in that individual's multi-agency plan of services (MAPS). The OHCDS provider must adhere to DDS ACS Waiver regulations as outlined in this provider manual. The OHCDS assumes all liability for services provided and/or performed by a sub-contracted entity.

210.000 PROGRAM COVERAGE 10-13-03

211.000 Scope 5-1-06

The Arkansas Medical Assistance Program (Medicaid) offers certain home and community based services as an alternative to institutionalization. These services are available for eligible individuals with a developmental disability who would otherwise require an intermediate care facility for the mentally retarded (ICF/MR) level of care. The home and community based services to be provided through this waiver are described herein as the DDS Alternative Community Services Waiver Renewal, hereafter referred to as DDS ACS Waiver.

As stated in the DDS ACS Waiver, "waiver services will not be furnished to persons while they are inpatients of a hospital, Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR) unless payment to the hospital, NF, or ICF/MR is being made through private pay or private insurance."

Services provided under this program are as follows:

A. ACS Supportive Living
B. Community Experiences
C. ACS Respite Care
D. ACS Non-Medical Transportation
E. ACS Waiver Coordination
F. Supported Employment
G. Adaptive Equipment
H. Environmental Modifications
I. ACS Specialized Medical Supplies
J. Supplemental Support Service
K. Case Management Services
L. Consultation Services
M. Crisis Intervention Services
N. Crisis Center

213.100 ACS Supportive Living Exclusions 5-1-06

Only hired caregivers may be reimbursed for supportive living services provided.

Payments for supportive living services will not be made to the parent, stepparent or legal guardian of a person less than 18 years old.

Payments will not be made to a spouse.

The payments for these services exclude the costs of room and board, including general maintenance, upkeep or improvement to the individual's own home or that of his or her family.

Routine care and supervision for which payment will not be made are defined as those activities that are necessary to assure a person's well being but are not activities that directly relate to active treatment goals and objectives.

See section 270.000 for billing information.

214.000 Community Experiences 5-1-06

Community experiences services are a flexible array of supports designed to allow individuals to gain experience and abilities that will prevent institutionalization. Through this broad base of learning opportunities, participants will identify, pursue and gain skills and abilities in activities that reflect their interests.

This model helps to improve community acceptance, employment opportunities and general well-being. The services are preventive, therapeutic, diagnostic and habilitative and will create an environment that will promote a person's optimal functioning.

The model also teaches developmental and living skills in the natural environment or clinic setting to ensure maximum learning and generalization. The services focus on enabling the person to attain or maintain his or her potential functional level and must be coordinated with any physical, occupational or speech therapies listed in the plan of care. These services reinforce skills or lessons taught in school, therapy or other settings.

When supports are provided in a clinic setting and the individual receives four or more hours of support, a noon meal is included in the service.

Services include activities and supports to accomplish individual goals or learning areas, including recreation and/or for specific training or leisure activities. To participate in community experiences activities, an individualized plan of treatment is required. Each activity is then adapted according to the participant's needs. Activities DDS may approve under this service include but are not limited to:

A. Community Based Time Management
B. Home Safety (sanitation, food handling, laundry, chemical storage)
C. Etiquette/Manners
D. Physical Exercise
E. Literacy
F. Job Interviewing Skills
G. Interpersonal Skills
H. Sex Education
I. Self Care/Proper Attire
J. Budgeting
K. Diet/Nutrition
L. Verbal Communication Skills
M. Self Improvement
N. Mental Health Support Groups
O. Adapted Curriculum AA Groups

P. Understanding Medications (e.g., what medication is used for, side effects, how to contact the physician or emergency services, how to communicate with a physician, understanding various lab and X-ray procedures, fear abatement, etc.)

Q. Disability Support Groups

See section 270.000 for billing information.

223.000 Case Management Services 5-1-06

Case management services refer to a system of ongoing monitoring of the provision of services included in the waiver participant's multi-agency plan of service (MAPS). Case managers initiate and oversee the process of assessment of the individual's level of care and the review of MAPS at specified reassessment intervals.

Case management services include responsibility for locating, coordinating and monitoring:

A. All proposed waiver services

B. Other Medicaid State Plan services

C. Needed medical, social, educational and other publicly funded services regardless of the funding source

D. Informal community supports needed by individuals and their families

The intent of case management services is to enable waiver participants to receive a full range of appropriate services in a planned, coordinated, efficient and effective manner.

Case management services consist of the following activities:

A. Arranging for the provision of services and additional supports

B. Monitoring and reviewing participant services

C. Facilitating crisis intervention

D. Guidance and support

E. Case planning

F. Needs assessment and referral for resources

G. Follow-along to ensure quality of care

H. Case reviews that focus on the individual’s progress in meeting goals and objectives established through the case plan

I. Assuring the integrity of all case management Medicaid waiver billing in that the service delivered must have prior authorization and meet required waiver service definitions and must be delivered before billing can occur

J. Assuring submission of timely (advance) and comprehensive behavior and/or assessment reports, continued plans of care, revisions as needs change and information and documents required for ICF/MR level of care and waiver Medicaid eligibility determination

K. Arranging for access to advocacy services as requested by consumer in the event that case management and direct service are the same provider entry

Service gaps of thirty (30) consecutive days must be reported to the DDS Specialist assigned to the case with a copy of the report sent to the DDS Program Director. The report must include the reason for the gap and identify remedial action to be taken.

Case management services are optional for some level categories and are available at three service levels. They are:

A. Pervasive – Minimum of one personal visit AND one other contact monthly

B. Extensive – Minimum of one personal visit OR one other contact monthly

C. Limited – Minimum of one personal visit each quarter

The level is determined by the needs or options of the person receiving waiver services as defined in sections 230.000 through 230.300.

See section 270.000 for billing information.

230.210 Service Levels 5-1-06

Coverage is provided within three service levels. Service levels are defined as pervasive, extensive and limited.

230.211 Pervasive Service Level 5-1-06

The pervasive service level is defined as needs that require constant supports provided across environments that are potentially life sustaining in nature. Supports are intrusive and long term and include a combination of any available waiver supports provided 24 hours a day, 7 days a week for 365 days a year with case management at the highest level (minimum of one personal visit and one other contact monthly). Sublevels are:

A. People who are adjudicated under Act 609; are receiving Department of Health and Human Services (DHHS) Integrated Supports; are civil commitments; are children in custody of the Division of Children and Family Services (DCFS) and who are receiving services through the Children's Adolescents Special Services Programs.

B. Human Development Center (HDC) residents transitioning to community living.

C. Nursing facility residents transitioning to community living.

D. Individuals who have compulsive behavior disorder that is life threatening and appropriate care in a group setting would be a violation of the rights of others.

E. People who meet the pervasive service level as defined in the waiver document and as determined eligible based on the Inventory for Client and Agency Planning (ICAP) assessment process.

F. Procedures for requesting pervasive service level:

1. To request Pervasive Service Level, the Case Manager must submit the following items to the DDS Waiver Specialist:
   - a. Documentation of any medical, behavioral or other changes that would justify the need for pervasive service level.
   - b. Copy of the current plan of care.
   - c. Copy of the person's case management notes for the past year if request is due to behavior.
   - d. If the reason for pervasive service level is in whole or in part due to behavior issues, a copy of the most recent psychological information on behavioral intervention efforts to include:
     - (1). A functional/behavior analysis of inappropriate behavior including possible antecedents
     - (2). Description of inappropriate behaviors and consequences
     - (3). Information related to increases or decreases in inappropriate behavior including time involved and frequency
     - (4). Positive programming changes to include a description of the behaviors attempting to be established to replace the inappropriate behavioral expression.
   - e. Copy of the computer generated or signed narrative report for the ICAP results which includes:
     - (1). ICAP Domain scores (age scores and standard scores)
     - (2). Information on problem behaviors recorded in the ICAP
     - (3). ICAP Maladaptive Behavior Index Scores
     - (4). ICAP Service Score/Level

(5). The name and relationship of respondent must be clearly noted.

(6). The name and credentials of the person administering and writing the report must be clearly noted.

2. DDS Waiver Staff will do the following things upon receipt of a request for pervasive service level:

a. The Waiver Specialist will check with DDS Licensure to see if any incident reports have been filed related to the individual. If any incident reports have been filed a copy will be obtained for the plan of care meeting.

b. The Waiver Manager will check the Incident Reporting Information System (IRIS) to see if any reports have been filed related to the individual. If any reports have been filed on IRIS, a summary will be compiled for the plan of care meeting.

c. The Waiver Audit staff will check the Medicaid Management Information System (MMIS) and all waiver prior authorizations issued and payments for waiver services for the past year.

3. If the request packet is not complete, it will not be accepted. Retroactive approval will not be granted on pervasive service level although emergency approval pending receipt of required documents and determination may be obtained from the Assistant Director of Adult and Waiver Services. Emergency requests may be made via fax. For emergency requests, all the required documentation listed in this rule must be submitted within two working days.

4. If the Plan of Care team cannot make a decision on pervasive service level and needs additional information, they will request assistance from the DDS Psychological team.

5. If assistance is requested from the DDS Psychological Team, the DDS Psychological team will convene within five working days following the Plan of Care meeting.

6. If the Plan of Care team requires additional information due to information not being complete or based on review of Incident Reports or IRIS, the time frame for approving of pervasive service level will start over.

7. All requests for pervasive service level will be reviewed at the weekly plan of care meetings.

230.212 Extensive Service Level 5-1-06

The extensive service level is defined as needs that require daily supports in one or more of a work, home or community environment. Supports are less intrusive than supports that may be needed daily but less than 24 hours per day or 7 days a week. Supports are long-term and may require intermittent, short-term crisis intervention in response to episodic behavior needs.

Supports include habilitation, residential habilitation reinforcement and other assisted living waiver services based upon individual needs. Case management is available at a reduced level of minimally one visit or contact per month.

230.213 Limited Service Level 5-1-06

The limited service level is defined as supports that are anticipated to be for the foreseeable future. They are individually time-limited and may be intermittent in nature and are subject to re-evaluation every 12 months. This level of support requires that parental support, group settings and community assistance be available to the individual.

Intermittent and time-limited supports are supports for primary caregiver relief, employment training, transitional supports, crisis behavior management and assisted living supports.

Case management for this Level I is a minimum of one visit per quarter. When case management is not chosen as a service component there must be a willing, responsible adult to assume all case management functions. Sublevels are:

Supported living arrangements: Provided for beneficiaries of DDS-funded supported living arrangements. General revenue must be available and in use for the existing service level with supporting general revenue to be used for the payment of Medicaid match in order for waiver conversion to occur. There are two categories of supported living arrangements:

A. Moderate supported living services level – at least15 days of service per month inclusive of case management and

B. Minimal supported living services level – at least10 days of service per month inclusive of case management.

230.223 Supportive Living Arrangement Model 5-1-06

In the supported living arrangement model, care is provided in DDS-supported living arrangements, in supported living apartments, in home and in group homes up to (but not inclusive of) 15 beds.

Supported living, community experiences, respite, waiver coordination and non-medical transportation are available for one rate of reimbursement with at least one service component being provided on at least 15 days each month for the moderate level or at least 10 days each month for the minimum level.

Under this model, the provider must deliver the service level needed regardless of minimum service provision requirements. Case management, crisis center and crisis intervention is available and payable in addition to the monthly rates.

Living arrangements include:

A. Existing group homes serving groups of no more than 14 unrelated adults (age 18 and above) with developmental disabilities in the residential setting.

B. Existing DDS licensed supportive living apartments serving up to 4 unrelated adults (age 18 and above) with developmental disabilities in each self-contained apartment unit up to the total number of licensed units in the complex.

C. Adults served in their family home, in their own home or in an integrated apartment complex or in an alternative living setting with no more than 4 unrelated adults with developmental disabilities in the home.

D. Children served in their family home or in the home of an alternative family with no more than 4 unrelated children with developmental disabilities in the home.

Exception: Only those supportive living apartments and group homes licensed by the DDS prior to July 1, 1995, are approved to serve more than 4 adults. No expansions will be approved beyond the July 1, 1995, total capacity (waiver and non-waiver).

230.410 MAPS for All Category Types 5-1-06

A. General Information

Identification information must include:

1. Recipient's full name and address
2. Recipient's Medicaid number
3. Guardian with an address (when applicable)
4. Individuals with MR/DD residing in home of waiver recipient
5. Physician Level of Care Certification/Prescription
6. Names, titles and signatures of the multi-agency team members responsible for the development of the recipient's multi-agency plan of service (MAPS)

B. Budget Sheet, Worksheets and Level of Care

Information must include:

1. Identification of waiver services

2. Services provider
3. Total amount by service
4. Total plan amount
5. Beginning and ending date for each service
6. Supported Living Array worksheet listing units and total cost by service
7. Adaptive Equipment/Environmental Modifications and Specialized Medical/Supplemental Support worksheets listing units and total cost by service
8. Level of Care sheet showing case management/waiver coordinator providers and staff and level of care.

C. Narrative Justification Initial Plan of Care and Continued Care Reviews

Justification must, at a minimum:

1. Identify progress or regression
2. Detail exceptional events such as major illness, injury, loss of primary caregiver(s), loss of home, graduation, awards, etc., that impacted service delivery and have a direct cause and effect for future needs.
3. Specify justification for requested services and identify consumer satisfaction level.

230.420 MAPS 5-1-06

A. The MAPS for individual, group and self-directed option categories must include proposed outcomes, immediate and long term needs.

B. In addition to the information detailed in Section 230.410, the following information must also be included:

1. Identification of individual outcomes expected
2. Review date
3. List of medical and other services, including waiver and non-waiver services necessary to obtain expected outcomes.
4. Service barriers

C. Product and service cost effectiveness certification statement, with supporting documentation, certifying that products, goods and services to be purchased meet applicable codes and standards and are cost competitive for comparable quality.

250.000 PRIOR AUTHORIZATION 10-13-03

ACS Waiver Program services require prior authorization by the Division of Developmental Disabilities Services. **In the absence of prior authorization, reimbursement will be denied and will not be approved retroactively.**

251.000 Approval Authority 5-1-06

For the purpose of plan of care and service approvals, DDS, a Division under the umbrella of the Department of Health and Human Services, is the Medicaid authority.

A. The DDS prior authorization process requires that all annual plans of care projected to cost over $50,000.00 must have approval by DDS Plan of Care Review authority. This cost threshold is subject to reduction by DDS.

B. Plans of care projected to cost under $50,000.00 will be subject to a more local level approval process.

C. All waiver services must be needed to prevent institutionalization.

D. All persons receiving medications must also receive appropriate support in the management of medication(s). The use of psychotropic medications will require the development, implementation and monitoring of a written medication management plan.

E. Service requests that will supplant Department of Education responsibilities WILL NOT be approved.

F. All plan of care reviews are subject to review by a qualified physician and random audit scrutiny. In addition, the following activities will occur:

1. Review of provider standards and actions that provide for the assurance of a person's health and welfare
2. Monitoring of compliance with standards for any state licensure or certification requirement for persons furnishing services provided under this waiver
3. Assurance that the requirements are met on the date that services are furnished
4. Quality assurance reviews by DDS staff to include announced and unannounced quarterly on-site visits
5. Random review equal to a percent as prescribed by DDS Licensure/Certification policy

G. All service requests are subject to review by DDS and may necessitate the gathering and submission of additional justification, information and clarification before prior approval is made. In this event, it is the primary responsibility of the case management provider, with cooperation from the procurement source, to satisfy the request(s) within the prescribed time frames.

H. It is the responsibility of the case management services provider with cooperation from the direct services providers to ensure that all requests for services are submitted in a timely manner to allow for DDS prior authorization activities.

I. Initially, an individual receives up to three months of DDS ACS Waiver Services based on a DDS pre-approved interim plan of care. The pre-approved interim plan of care will include case management and waiver coordination.

1. At any time during the initial three months, the providers will complete the multi-agency planning process and submit a detailed plan of care that identifies all needed, medically necessary services for the remainder of the annual plan of care year. Once approval is obtained, the additional services may be implemented.
2. ACS Waiver Services will not be reimbursed for any date of service that occurs prior to the date the individual's plan of care is approved or the date the individual is determined ICF/MR level of care and is deemed Medicaid/waiver eligible, whichever date is last.
3. All changes of service or service level revisions that occur within an approved annual plan of care must also have prior approval and there will be no reimbursement for any services not prior-approved.

J. Emergency approvals may be obtained via telephone, facsimile or e-mail, with retroactive reimbursement permitted as long as the notice of emergency, with request for service change, is received by DDS within 24 hours from the time the emergency situation was known. All electronically transmitted requests for emergency services must be followed with written notification and requests must be supported with documented proof of emergency.

262.000 Rate Appeal Process 5-1-06

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 and/or 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 wishes, for a full explanation of the factors involved and the Program decision. Following review, 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 and/or provider conference.

When the provider disagrees with the decision made by the Assistant Director of the Division of Medical Services, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) management staff, who will serve as chairperson.

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 of the 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 panel will hear the questions and a recommendation will be submitted to the Director of the Division of Medical Services.

272.100 DDS ACS Waiver Procedure Codes 5-1-06

The following procedure codes and any associated modifier(s) must be billed for DDS ACS Waiver Services. Prior authorization is required for all services.

Procedure Code	M1	M2	PA	Description	Unit of Service	POS for Paper Claims	POS for Electronic Claims
A0080			Y	ACS Non-Medical Transportation	1 Year	0	99
H2016			Y	ACS Supportive Living (Individual)	1 Year	4, 0	12, 99
H2016	UB		Y	ACS Supportive Living (Group)	1 Year	4, 0	12, 99
H2023[1]			Y	Supported Employment	15 Minutes	0	99
S5151			Y	ACS Respite Care	1 Year	4, 0	12, 99
T2020			Y	Community Experiences	1 Year	4, 0	12, 99
T2020	UA		Y	Supplemental Support Services	1 Year	4, 0	12, 99
T2022			Y	Case Management Services	1 Month	4, 0	12, 99
T2024			Y	ACS Waiver Coordination	1 Year	4, 0	12, 99
T2025[2]			Y	Consultation Services	1 Hour	4, 0	12, 99
T2028[3]			Y	ACS Specialized Medical Supplies	1 Year	4, 0	12, 99
T2034			Y	Crisis Center	1 Year	0, 4	99, 12
T2034[4]	U1	UA	Y	ACS Crisis Intervention Services	1 Hour	0, 4	99, 12

[1] Individuals are limited to a maximum of 32 units (8 hours) of supported employment services per date of service.

A breakdown of the supported employment units of service includes:

One unit = 15 minutes to 21 minutes
Two units = 22 minutes to 37 minutes
Three units = 38 minutes to 52 minutes
Four units = 53 minutes to 67 minutes

[2] Beneficiaries may receive twenty-five (25) hours of ACS consultation services per waiver-eligible year.

[3] Reimbursement cannot exceed $300 per month.

[4] Crisis intervention services may require a maximum of 24 hours of service during any one day.

The following list contains the procedure codes used for ACS physical adaptations. Physical adaptations have a benefit limit of $7500 per year.

Procedure Code	M1	M2	PA	Description	POS for Paper Claims	POS for Electronic Claims
K0108			Y	⁂(ACS environmental modifications) Other accessories	4	12
S5160			Y	⁂(Adaptive equipment, personal emergency response system [PERS], installation and testing) Emergency response system; installation and testing	4	12
S5161			Y	⁂(Adaptive equipment, personal emergency response system [PERS], service fee, per month, excludes installation and testing) Emergency response system; service fee, per month (excludes installation and testing)	4	12
S5162			Y	⁂(Adaptive equipment, personal emergency response system [PERS], purchase only) Emergency response system; purchase only	4	12
S5165	U1		Y	⁂(ACS adaptive equipment) Home modifications, per service	4	12

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

Refer to section 272.200 for definitions of the place of service codes listed above.