CHAPTER 1200

ARIZONA LONG TERM CARE SYSTEM SERVICES AND SETTINGS FOR MEMBERS WHO ARE ELDERLY AND/OR HAVE PHYSICAL DISABILITIES AND/OR HAVE DEVELOPMENTAL DISABILITIES

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1200 CHAPTER OVERVIEW

This chapter provides a description and discussion of the amount, duration and scope of home and community based services (HCBS), including alternative residential settings, and institutional services provided by AHCCCS through the Arizona Long Term Care System (ALTCS) to members who are either elderly and/or have physical disabilities and to members who are determined to have developmental disabilities (DD). The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and evaluation of services provided to members. The member's instrumental activity of daily living (IADL) capacity, as well as the activity of daily living (ADL) capacity must be taken into consideration when determining the service plan that is appropriate to the member's needs. Members are to be maintained in the most integrated setting appropriate for their needs. To that end, members are afforded choice in remaining in their own home, or choosing and alternative residential setting versus entering an institution.

Members are those individuals who are eligible for ALTCS services and enrolled with an ALTCS Contractor, ADES/DDD or a Tribal Contractor. All services provided to ALTCS members with DD are provided through the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD). The financial and medical eligibility determination process for ALTCS members is conducted by the AHCCCS Division of Member Services. For purposes of this Chapter, ALTCS Contractors and Tribal Contractors will be referred to as ALTCS Contractors or Contractors, unless otherwise noted to increase clarity.

The chapter also provides information regarding the approved setting in which the HCB and institutional services may be provided. Service providers must also be appropriately licensed, registered or certified by a State governing board or agency and must be registered as an AHCCCS provider.

Each ALTCS member is assigned a case manager who coordinates care with the member's primary care provider and is responsible for authorizing and monitoring all services provided through ALTCS as described in this Chapter. The number and frequency of HCB services or the placement of a member in an alternative residential, community residential or community behavioral health setting is determined by member need and through the Cost Effectiveness Study conducted by the member's case manager. Detailed information regarding ALTCS case management functions and responsibilities can be found in Chapter 1600 of this Manual.

ALTCS provides HCBS for its members through a waiver from the Centers for Medicare and Medicaid Services (CMS). Contractors are encouraged by AHCCCS to serve members in their own home or place members in HCB alternative settings whenever possible. The cost of room and board in a HCB setting is not reimbursable.

Managed Care

ALTCS requires the Managed Care Contractors to implement prior authorization (PA) procedures for inpatient hospital services, and also encourages them to implement PA and medical management methods for other services, as they deem appropriate. To obtain information regarding Contractor PA requirements for specific services, contact the member's Contractor.

If an ALTCS service requiring PA is denied, reduced, suspended or terminated by a Contractor (including ADES/DDD), the provider and the member must be notified of the action. Contractors must comply with the notice of action requirements specified in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

Fee for Service (FFS)

Native Americans who are living "on-reservation", are ALTCS-enrolled, and are either members who are elderly or with physical disabilities receive ALTCS HCBS and institutional services through the ALTCS FFS program. Case management for these members is provided through a Tribal Contractor.

AHCCCS requires PA through the AHCCCS Division of Fee for Service Management (DFSM) for some covered acute care services provided to members who receive services through a Tribal Contractor. Exceptions include emergency, dental, and behavioral health services, as well as some preventive services. PA is required for the following services when provided to a Native American ALTCS FFS member:

1. Non-Medicare covered podiatry services

2. Non-Medicare covered physician services for scheduled surgeries

3. Non-emergency transportation between acute care facilities

4. Acute care hospitalization in a non-IHS hospital

5. Non-emergency hospitalization

6. Specialty rates for facilities and Above Level of Care facility rates, and

7. Home modifications (Refer to form in Policy 1240).

Medical review is required for the following services when provided to a Native American ALTCS FFS member:

1. Durable medical equipment (DME), when the cost exceeds $500 (items between $300 and $499 must be authorized by the FFS case manager and included on the CA165)

2. Medically necessary dentures

3. Medically necessary incontinence supplies (e.g., diapers and Chux). This does not include catheters, ostomy supplies, etc.

4. Specialty beds and wound care treatments, and

5. Medically necessary oral nutritional supplements (refer to form in Policy 1250).

Refer to Chapter 800 in this Manual for additional information on AHCCCS FFS PA requirements.

If PA is denied or services are denied, reduced, suspended or terminated, refer to 9 A.A.C. 34 for information regarding notification requirements for FFS providers and members. Refer to the concurrent review section of Chapter 800, Policy 810, for information related to approval or denial of the continuation of inpatient hospital services.

Exceptions for On-Reservation Facilities and Providers

1. Most health care facilities located on Native American reservations, and Indian Health Service hospitals regardless of location, are not required to be licensed by the State of Arizona. However, some facilities may require Federal certification. An example is Medicare/Medicaid certification for nursing facilities.

2. Approval for on-reservation tribal service providers and settings is coordinated by AHCCCS and approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Out-of-State Services

Services provided outside the State of Arizona are covered as provided for under Title 42 of the Code of Federal Regulations (42 CFR), Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states or are services needed due to a medical emergency. Providers must register with AHCCCS for reimbursement. Services furnished to AHCCCS members outside the United States are not covered. AHCCCS will not register providers who are located outside the United States or who provide services solely outside the United States.

Note: "United States" (U.S.) includes the 50 states of the U.S., the District of Columbia, and the U.S. Territories (Puerto Rico, U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

Exhibits/Appendices

The following Exhibits can be found at the end of each policy. Appendix J can be found at the end of this manual. Managed care Contractors are not required to conform to those Exhibits/Appendices that are specifically designated for the use of the AHCCCS FFS program.

1. Exhibit 1210-1 identifies durable medical equipment included in the FFS per diem rate for nursing facilities and intermediate care facilities for the mentally retarded.

2. Exhibit 1210-2 lists medical supplies included in the FFS per diem rate for institutional services.

3. Exhibit 1220-1 provides a copy of the Level I Pre-Admission Screening and Resident Review reporting form.

4. Exhibit 1230-1 provides a table of HCB alternative residential settings and service codes.

5. Exhibit 1240-1 identifies medical supplies included in the FFS rate for home health nurse visits.

6. Exhibit 1240-2 identifies covered home health nursing services that may be provided by professional nurses (Registered Nurses and Licensed Practical Nurses).

7. Exhibit 1240-3 identifies whether service authorization is to be obtained from the case manager or if PCP orders are required for the various components of HCBS.

8. Exhibit 1240-4 provides a copy of the AHCCCS/ALTCS FFS Home Modification Request/Justification form.

9. Exhibit 1240-5 provides a copy of the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements

10. Exhibit 1240-6 provides a table of HCB services, service codes and applicable units of service, and

11. Appendix J contains information and the required form for mileage reimbursement for FFS providers.

Refer to the AHCCCS FFS Provider Manual and the IHS/Tribal Billing Manual for FFS claims billing information. Both of these manuals are available on the AHCCCS Web site (www.azahcccs.gov).

Refer to the specific Contractor for managed care claims billing information.

- **REFERENCES**

1. Title 42 of the Code of Federal Regulations (42 CFR) 483.108, 483.114, 483.116, 483.118, 483.120 (PASRR)

2. 42 CFR, Part 431, Subpart B (Out of State Services)

3. Arizona Revised Statutes (A.R.S.) 32-1101 et seq. (Home Modification Contractor)

4. Chapter 100 of this Manual includes 42 CFR, State Statute and Rule citations related to services and settings addressed in this Chapter.

5. Chapter 600 of this Manual, Exhibit 610-1, includes 42 CFR, State Statute and Rule citations related to provider requirements.

6. AHCCCS ALTCS Contracts

7. Tribal Intergovernmental Agreements (IGAs)

8. AHCCCS memo dated September 4, 1997 "Medicaid Payments for Foreign Country Providers".

1210 INSTITUTIONAL SERVICES AND SETTINGS

Description. AHCCCS/ALTCS covers medically necessary institutional services provided in an AHCCCS registered long term care facility for ALTCS members who are either elderly and/or have physical disabilities (E/PD) or who have been determined by the Arizona Department of Economic Security/Division of Developmental Disabilities to be developmentally disabled (DD) and at immediate risk of institutional placement.

Note: ALTCS members who are in the transitional program are not eligible for nursing facility (NF) services or intermediate care facility for the mentally retarded (ICF/MR) services exceeding 90 continuous days per admission.

Descriptions of these settings are as follows:

Nursing facility, including religious non-medical health care institutions

The nursing facility (NF) must be licensed and Medicare/Medicaid certified by the Arizona Department of Health Services in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis, but who do not require hospital care or direct daily care from a physician. Religious non-medical health care institutions are exempt from State licensing requirements as are on-reservation NFs.

Intermediate Care Facility for the Mentally Retarded (ICF/MR)

A health care institution, Medicaid certified through ADHS and monitored by the Arizona Department of Economic Security (ADES), providing room and board and whose primary purpose is to provide health, habilitative and rehabilitative services to individuals with developmental disabilities.

Amount, Duration and Scope. For ALTCS NF and ICF/MR institutional services, each unit of service constitutes a 24 hour day (per diem), and includes:

1. Nursing care services, including rehabilitation, restorative services and respiratory care services

2. Social services

3. Dietary services, including, but not limited to, preparation and administration of special diets and adaptive tools for eating

4. Recreational therapies and activities

5. Overall management and evaluation of the facility's plan of care for the member

6. Observation and assessment of the member's changing condition

7. Room and board services, including, but not limited to, support services such as food, personal laundry and housekeeping

8. Nonprescription and stock medications, and

9. Durable medical equipment (DME) and medical supplies as negotiated per contract between the facility and ALTCS managed care Contractor including customized DME (as defined in Chapter 100) if specified. Exhibit 1210-1 provides a listing of DME included in the per diem for the ALTCS FFS program. Exhibit 1210-2 addresses medical supplies included in the per diem for the ALTCS FFS program. (This applies to NFs only.)

In addition, the following services must be available to members residing in an ALTCS institutional setting, but are not included in the service unit.

1. Speech, physical and occupational therapies unless required as a part of the per diem for the service unit

2. Medical/acute care services as specified in Chapter 300. Medical/acute care services provided to ALTCS Contractor members are the same as those provided to acute care Contractor members.

3. Customized DME ordered by the member's primary care provider and authorized by the Contractor or by the AHCCCS Administration for FFS members

4. Professional services provided by Behavioral Health Independent Billers, who may report/bill services separately from the facility (see definition in Glossary of Appendix G). Refer to Appendix G for further information on AHCCCS covered behavioral health services and settings.

5. Hospice services (refer to Policy 1250 for detailed information regarding components of this service), and

6. EPSDT services as specified in Chapter 400, Policy 430 of this Manual.

Institutional settings also include Behavioral Health Level I, Institution for Mental Disease (IMD), and Inpatient Psychiatric Residential Treatment Center. ALTCS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this manual.

Behavioral Health Level I

A behavioral health service facility licensed by ADHS, as defined in A.A.C. 20, to provide a structured treatment setting with 24-hour supervision, on-site medical services and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services (other than psychiatric hospitalization). Some Level I facilities are IMDs.

Institution for Mental Disease (IMD)

A Medicare-certified hospital, special hospital for psychiatric care, behavioral health facility or nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Level I facilities with more than 16 beds are considered IMDs.

Reimbursement for services provided in an IMD to Title XIX persons age 21 through 64 years of age is limited to 30 days per inpatient admission, not to exceed a total of 60 days per contract year. For Title XIX members under age 21 and 65 years of age and older, there is no benefit limitation. A Title XIX member aged 21 through 64 will lose eligibility for covered services if an IMD stay extends beyond 30 days per admission or 60 cumulative days per year (July 1 through June 30). A Title XIX member who is receiving services until the point in time in which services are no longer required or the member turns age 22, whichever comes first. AHCCCS provider types B6 and 71 are IMDs.

Inpatient Psychiatric Residential Treatment Center (available to Title XIX members under 21 years of age)

A behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities and experiences designed to meet the treatment objectives for the member. A Title XIX member who turns age 21 while receiving services in an inpatient psychiatric facility considered to be an IMD may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.

Amount, Duration and Scope.

For behavioral health institutional services, each unit of service constitutes a 24-hour day (per diem), and includes:

1. Nursing care services, including rehabilitation
2. Social services
3. Dietary services, including, but not limited to, preparation and administration of special diets
4. Recreational therapies and activities
5. Overall management and evaluation of the facility's plan of care for the member
6. Observation and assessment of the member's changing condition
7. Room and board services, including, but not limited to, support services such as food, personal laundry and housekeeping, and
8. Nonprescription and stock medicines.

In addition, the following services must be available to members residing in an ALTCS institutional setting, but are not included in the service unit:

1. Speech, physical and occupational therapies unless required as a part of the per diem for the service unit

2. Medical/acute care services as specified in Chapter 300 of this manual. Medical/acute care services provided to ALTCS Contractor members include all those services provided to acute care Contractor members.

3. Professional services provided by behavioral health independent billers, who may report/bill services separately from the facility (see definition in Glossary of Appendix G).

Refer to Appendix G for further information on AHCCCS covered behavioral health services and settings.

EXHIBIT 1210-1

DURABLE MEDICAL EQUIPMENT INCLUDED IN THE NURSING FACILITY AND INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED FEE-FOR-SERVICE PER DIEM RATE

EXHIBIT 1210-1

DURABLE MEDICAL EQUIPMENT INCLUDED IN THE NF AND ICF/MR FFS PER DIEM RATE

Under 9 A.A.C. 22, Article 2, DME is included in the per diem rate of NFs and ICFs/MR. This list is not all-inclusive and its purpose is as a general reference only.

The following equipment is included in the per diem rate:

Accucheck monitors
Alternating pressure mattress and pump
Bedside commode
Canes
Crutches
Cushions
Feeding pumps
Foot cradles
Geri-chairs (all non-customized)
Heating pads
Hospital beds (electric and manual)
Nebulizers
Lifts
Suction machines
IV poles
Walkers (all non-customized)
Water mattress
Wheelchairs (all non-customized)

Customized DME (as defined in Chapter 100) may be provided to members if the items are ordered by the member's primary care provider and authorized by the member's Contractor or the AHCCCS Administration for FFS members.

EXHIBIT 1210-2

MEDICAL SUPPLIES INCLUDED IN THE NURSING FACILITY FEE-FOR-SERVICE PER DIEM RATE

EXHIBIT 1210-2

MEDICAL SUPPLIES INCLUDED IN THE NF FFS PER DIEM RATE

Under 9 A.A.C. 22, Article 2, all supplies (nursing, medical, and over the counter pharmaceutical supplies) are included in the NF per diem rate. Some of the more common supplies used are listed below. This list is not all-inclusive and its purpose is as general reference only.

Ace bandages
Alcohol wipes
Bath and grooming supplies
Catheters
- Angio
- Foley
- Suction
- Texas

Catheter irrigation sets
Catheter trays
Chemstrips
Chux
Cotton balls
Cotton rolls
Douches
Drainage bags
Dressing, sterile/nonsterile
Duoderm
Enema sets
Enema Basins
First aid supplies
Gauze pads
Gloves, sterile/nonsterile
Glycerine swabs
Gowns, patient and isolation
Hydrogen peroxide
Heel protectors
Humidifiers
Ice bags
Identification system
Incontinence pads and briefs
Kerlix
Kling
Laxatives
Linen
Medication cups
N/G tubing and connectors
Needles (all sizes)
Opsite
Ostomy supplies
OTC pharmaceuticals
Passive restraints
Skin lotions
Slings
Sponges
Stockinette
Syringes (all sizes)
Tape (all types & sizes)
Ted hose
Thermometers
Toothettes
Tracheostomy tubing
Urine specimen cups

1220 FEDERALLY MANDATED PROGRAMS FOR NURSING FACILITIES

Description. AHCCCS requires registered nursing facilities (NFs) to comply with Federal mandates and requirements for resident assessment, nurse aide training and competency evaluation program and Pre-Admission Screening and Resident Review (PASRR) in order to provide ALTCS long-term care services. The three programs are addressed below.

- **RESIDENT ASSESSMENT**

1. NF providers must complete a resident assessment for each resident within 14 days of admission, using an approved Resident Assessment Instrument (RAI). The ALTCS approved RAI uses two components listed below:

   a. The Minimum Data Set (MDS) is the standardized, functionally based evaluation tool used to assess each resident's ability to perform daily life functions; and

   b. The Resident Assessment Protocol uses the information obtained from the MDS evaluation process to assess potential problem and risk areas.

2. The RAI must be completed by a registered nurse; information regarding problem areas is then used to develop the member's individualized care plan.

3. A reassessment must be conducted within one year, or whenever there is a significant change in the resident's status, and

4. A quarterly review to assess key indicators or resident status must be completed and the plan of care revised as necessary.

- **NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM**

  1. AHCCCS registered NFs must comply with Federal standards to assure that nurse aides employed by the facility have completed necessary training and competency evaluation programs approved by the Arizona State Board of Nursing (ASBN). Nurse aides must also be included in the ASBN nurse aide registry.

  2. The ASBN is responsible for compliance with Federal standards in administering the nurse aide competency evaluation, approval of nurse aide training programs and establishing a nurse aide registry. The Arizona Department of Health Services is responsible for investigating complaints alleging abuse and/or neglect by nurse aides.

- **PRE-ADMISSION SCREENING AND RESIDENT REVIEW**

  1. AHCCCS registered NFs must provide Level I PASRR screening, or verify that a screening has been conducted, in order to identify serious mental illness (MI) and/or mental retardation (MR) prior to initial admission of individuals to a NF bed that is Medicaid certified or dually certified for Medicaid/Medicare.

     The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with MI and/or MR. Level I reviews are used to determine whether the member has any diagnosis or other presenting evidence that suggests the potential of MI or MR. Exhibit 1220-1 provides a copy of the Level I PASRR form. Level II reviews are conducted by ADES/DDD for MR members or ADHS for mentally ill members to further evaluate and make a determination as to whether the member is indeed mentally ill or has mental retardation. It also determines whether the member needs the level of care provided in NFs and/or needs specialized services as defined in #8 for MI or #7 for MR.

2. AHCCCS ALTCS Pre-Admission Screening (PAS) Assessors or case managers may conduct Level I PASRR screenings, but it is the ultimate responsibility of the NF to assure it is completed prior to admission to the NF. The PASRR must be completed by medical professionals such as hospital discharge planners, nurses or social workers.

3. A Level I PASRR screening is not required for readmissions of residents who were hospitalized and are returning to the NF, or for inter-facility transfers from another NF. All PASRR screening information should accompany the readmitted or transferred individual.

4. If the individual is to be admitted to the NF for a convalescent period, or respite care, not to exceed 30 days, a PASRR Level I screening is required. If it is later determined that the admission will last longer than 30 days, a new Level I PASRR screening must be completed as soon as possible. If a Level II PASRR is required, it must be completed within 40 calendar days of the admission date.

5. It is the responsibility of the NF or the ALTCS Contractor to make referrals for Level II PASRR evaluations if determined necessary. When the initial PASRR is conducted by the PAS assessor, it is the responsibility of the local AHCCCS/ALTCS office to make the Level II evaluation referral if indicated. The Division of Behavioral Health Services within the Arizona Department of Health Services (ADHS) should be contacted for a Level II evaluation of mental illness. The Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD) should be contacted for Level II evaluations of MR. Intergovernmental agreements among AHCCCS, ADHS and ADES/DDD have been established to develop and initiate the Level II evaluation process.

6. The outcome of the Level II PASRR evaluation will determine action to be taken by the NF. If the individual requires NF services, they may be admitted; all ALTCS members who were assessed as eligible with the PAS are appropriate for a nursing level of care. If they are admitted and are determined to need specialized services, the NF should contact the member's case manager to arrange for the required services. If the outcome of the Level II PASRR evaluation determines the individual does not require NF services or specialized services, no admission should take place.

7. Specialized services (for mental retardation) – Services specified by a mental retardation authority as the result of a Level II PASRR evaluation of any resident which, provided in conjunction with NF services, results in the implementation of an aggressive, consistent treatment program that:

    a. Allows acquisition of behaviors necessary for the ALTCS member to function as independently as possible, and

    b. Prevents or decreases regression or loss of the ALTCS member's current optimal level of functioning.

8. Specialized services (for mental illness) – Services specified by a behavioral health authority as the result of a Level II PASRR evaluation of any resident, which provided in conjunction with NF services, results in the implementation of an individual care plan that:

    a. Is developed and supervised by a interdisciplinary team composed of a physician, qualified behavioral health professionals and, as appropriate, other professionals

    b. Prescribes specific therapies and services for the treatment of ALTCS members experiencing an acute episode of serious mental illness which requires intervention by trained behavioral health personnel, and

    c. Is directed toward diagnosing and reducing the ALTCS member's behavioral symptoms that initiated the PASRR Level II evaluation for implementation of specialized services, and improving the member's level of functioning to the point that a reduction in the intensity of behavioral health services to below the level of specialized services may be accomplished at the earliest possible time.

9. If the individual's mental health condition changes, or new medical records become available that indicate the need for a Level II PASRR screening, a new Level I screening must be completed as soon as possible and a referral made.

10. The AHCCCS grievance and appeal system must be used for appeals (9 A.A.C. 34). These will be limited to individuals who believe they have been adversely affected by a Level II PASRR determination.

EXHIBIT 1220-1

PRE-ADMISSION SCREENING AND RESIDENT REVIEW SCREENING DOCUMENT – LEVEL I

STATE OF ARIZONA
INSTRUCTIONS (OVER)

PASRR SCREENING DOCUMENT
LEVEL I

ARIZONA HEALTH CARE
COST CONTAINMENT SYSTEM

A. PATIENT INFORMATION

1) NAME: last, first
_____

2) DATE OF BIRTH: _____/_____/_____

3) AHCCCS ID #: _____

4) PATIENT COMING FROM?
ADDRESS: Street, City, State, Zip Code, nurses' station

_____

_____

5) Receiving Facility Name: _____

_____

_____
(Include nurses' station)

B. EXEMPTIONS (circle answer)

6) YES NO Primary Diagnosis Dementia? (includes Alzheimer's or related)

7) YES NO Secondary Diagnosis Dementia without primary diagnosis of serious mental illness?

8) YES NO Diagnosis Dementia with mental retardation or related diagnosis and without an SMI diagnosis?

9) YES NO Convalescent care? (admission from hospital after receiving acute inpatient care, requires NF services for same condition and physician has certified before admission to NF that individual requires 30 days or less NF services).

10) YES NO Respite care? (brief and finite stay up to 30 days per period to provide respite to in-home caregivers to whom individual is expected to return).

C. IDENTIFICATION OF POTENTIAL MENTAL RETARDATION (circle answer)

MENTAL RETARDATION (MR) EVALUATION CRITERIA

11) YES NO Diagnosis of Mental Retardation (MR)?
12) YES NO History of MR/Developmental Disability?
13) YES NO Any presenting evidence to indicate MR?
14) YES NO Referred by agency serving MR clients or eligible for such services?
15) YES NO Individual has any of the following conditions diagnosed prior to 22nd birthday?

- Autism
- Seizure Disorder
- Cerebral Palsy
- Developmental Delays (children age 5 and under only)
- Epilepsy
- Mental Retardation

D. IDENTIFICATION OF POTENTIAL MENTAL ILLNESS (circle answer)

MENTAL ILLNESS (MI) EVALUATION CRITERIA

16) YES NO Primary Diagnosis of serious mental illness (SMI) defined in DSM IV as:

- Major Depression
- Psychotic Disorder
- Delusional Disorder (i.e. paranoid)
- Mood Disorder
- Schizophrenia

and

Level of impairment limiting life activities within the past 3 to 6 months

and

Recent treatment within the past two years?

E. REFERRAL ACTION (circle only one)

17) NO Referral Necessary for any Level II
18) YES Referral for Level II determination for MR only (ADES)
19) YES Referral for Level II determination for MI only (ADHS)
20) YES Referral for Level II determination for Dual MR/MI

F. Signature of Patient or Representative for a Level II PASRR

I understand that I am required to undergo a Level II evaluation as a condition of admission to or my continued residence in a Title XIX Medicaid Nursing Facility. I also give my permission to disclose all pertinent medical and personal information to any governmental agency involved in this evaluation.

_____ _____
Patient or Patient's Representative Date

G. Signature of Medical Professional Completing Level I PASRR

I understand that this report may be relied upon in the payment of claims that will be from Federal and State Funds, and that any willful falsification, or concealment of a material fact, may be prosecuted under Federal and State Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.

In addition, I acknowledge that information supplied in this report may be shared with other State agencies involved in patient screening.

_____ _____
Signature Title

_____ _____/_____
Print Name Telephone Number Date

Revised 03/2006

STATE OF ARIZONA ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PASRR SCREENING DOCUMENT
INSTRUCTIONS/EXPLANATION

PLEASE PRINT

Initial PASRR Identification and evaluation must take place Prior to Admission to a Medicaid certified nursing facility. If a referral for a Level II is indicated, the patient must not be admitted to a Medicaid certified nursing facility until the Level II portion of the evaluation process has been completed.

A. PATIENT INFORMATION

1. NAME: LAST FIRST
2. DATE OF BIRTH: month, day, year
3. INSERT AHCCCS ID# (IF APPLICABLE)
4. PT. COMING FROM: (where client is at time of Level I evaluation)
   PRINT: street address, city, State, zip code, nurses' station
5. RECEIVING FACILITY: INSERT NAME

THIS LEVEL I MR/MI IDENTIFICATION PROCESS IS COMPLETE WHENEVER A DECISION IS MADE IN SECTION "E", REFERRAL ACTION.

B. EXEMPTIONS

6. through 10. Please answer these questions based on the patient's current condition and the most recent medical information. IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", SKIP SECTIONS C AND D AND GO TO SECTION E "REFERRAL ACTION" AND INDICATE THAT NO REFERRAL FOR LEVEL II DETERMINATION IS NECESSARY.

C. IDENTIFICATION OF POTENTIAL MENTAL RETARDATION (MR)

11. through 15. IF THE ANSWER TO ANY OF THESE QUESTIONS IS "YES", GO TO SECTION E "REFERRAL ACTION" AND INDICATE THAT A REFERRAL FOR A LEVEL II DETERMINATION FOR MR [Department of Economic Security (ADES)] IS NECESSARY. Attach any supportive documentation.

D. IDENTIFICATION OF POTENTIAL MENTAL ILLNESS (MI)

16. IF THE ANSWER TO THIS QUESTION IS "YES", GO TO SECTION "E" REFERRAL ACTION" AND INDICATE THAT A REFERRAL FOR A LEVEL II DETERMINATION FOR MI [Department of Health Services (DHS)] IS NECESSARY. Attach any supportive documentation.

E. REFERRAL ACTION

17. through 20. CIRCLE ONLY ONE (1) ANSWER.

F. SIGNATURE OF PATIENT OR REPRESENTATIVE

Read the disclosure to the patient or representative and obtain signature prior to the Level II referral.

G. SIGNATURE OF MEDICAL PROFESSIONAL

Sign and complete the information as requested. Be sure to include a phone number.

Revised 03/2006

1230 HOME AND COMMUNITY BASED SERVICE SETTINGS

Description. Home and community based (HCB) alternative residential settings included in this policy are covered within the parameters described in this section for ALTCS members.

Each HCB alternative residential setting must be licensed or certified (as indicated in the following description of each setting) and registered as an AHCCCS provider. The costs for room and board in a HCB alternative residential setting is not covered by ALTCS and must be paid by the member or the member's family, guardian or representative.

Refer to Exhibit 1230-1 to view the table of settings and service codes.

Refer to Chapter 1600 for case management authorization requirements.

- **ASSISTED LIVING FACILITIES**

Description. Assisted living facilities (ALFs - assisted living center [ALC], assisted living home [ALH] and adult foster care [AFC] home) are residential care facilities licensed by the Arizona Department of Health Services (ADHS). An AFC home is a classification of an ALF and may be licensed by ADHS or certified by the County in which it is located. All ALFs are licensed to provide supervisory care (not generally covered by AHCCCS), personal care, or directed care services, as defined in the Arizona Administrative Code (A.A.C.), Title 9, Chapter 10, Article 7. ALFs are designed for ALTCS members who are physically or functionally unable to live in their own home with assistance, but do not need the care intensity of a nursing facility. They are classified according to the number of residents allowed to reside in the facility. Classifications are as follows:

Assisted Living Center (ALC)

The facility provides resident rooms or residential units and services to 11 or more residents. Members residing in an ALC must be provided the choice of single occupancy.

Assisted Living Home (ALH)

The facility provides resident rooms and services to ten or fewer residents.

Adult Foster Care Home

The facility provides adult foster care (AFC) services for at least one and no more than 4 adult residents, at least one of which must be an ALTCS member. In addition to services that are provided by other ALFs, AFC home services may be expanded depending upon the type of staffing available in the home. If the staff of the AFC home sponsor is authorized by law to provide nursing or medical services, and appropriate staff is on-site as needed by residents, members may receive services in these facilities regardless of the level of physical, emotional or behavioral health care required (other than hospitalization). This includes maximum assistance with mobility and activities of daily living, as well as medications and treatments.

Amount, Duration and Scope. Services provided by ALFs are based on a per diem rate for a 24-hour day. They include personal care and homemaker services. Room and board is not included as an ALTCS covered service. The room and board amount is determined by the ALTCS Contractor.

Services provided in addition to services included in the ALF per diem rate must be authorized by the member's Contractor after being determined medically necessary and cost effective. Those services not incorporated in the ALF per diem are billed separately by the service provider. They include medical acute care services, medical supplies and durable medical equipment, therapies, transportation, and behavioral health services, as well as home health services that comprise skilled nursing, continuous nursing or home health aide services, as applicable. Adult day health services may be provided only with specific detailed justification by the case manager and approval by the ALTCS Contractor or the AHCCCS Administration for FFS members.

Refer to Policy 1240 of this Chapter for a description of these services, and any limitations to ALTCS coverage.

Refer to A.A.C. Title 9, Chapter 10, Article 7, ALF Rules, for criteria for admission and services provided by ALFs.

Note: ALFs also include a demonstration pilot known as the Alzheimer's Treatment Assistive Living Facilities Pilot. It is an ALTCS approved alternative setting as provided for by Laws 1999, Ch. 313 §§ 35 (Assistive Living Facilities Demonstration Pilot Project). Alzheimer's Treatment Assistive Living Facilities were approved as a demonstration pilot effective October 1, 1999 and the pilot has been extended through December 31, 2007.

- **BEHAVIORAL HEALTH FACILITIES**

Description. The following behavioral health facilities are considered home and community based (HCB) alternative residential facilities that are approved ALTCS HCB settings for behavioral health services, as defined in Chapter 100. They are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, which are provided to ALTCS members who have a behavioral health disorder and are residing in one of the following behavioral health facilities:

1. Level II behavioral health facility – Licensed by Arizona Department of Health Services (ADHS). A HCB alternative residential behavioral health treatment setting for individuals who do not require the intensity of services or onsite medical services found in a Level I facility

2. Level III behavioral health facility - Licensed by ADHS. An HCB alternative residential behavioral health setting with 24 hour supervision and supportive, protective oversight

3. Therapeutic Foster Care Home - Licensed by ADHS for adults, or by Arizona Department of Economic Security/Administration for Children, Youth and Families for children. These facilities provide behavioral health services and ancillary services.

4. Rural Substance Abuse Transitional Agency (RSATA). Licensed by ADHS. An agency located in a county with a population of fewer than 500,000 individuals that provides inpatient and outpatient services to an individual who is intoxicated or has a substance abuse problem.

Amount, Duration and Scope. ALTCS members are eligible to receive AHCCCS covered medically necessary behavioral health services. Services in a Level II or III behavioral health facility are provided as a bundled treatment day. Room and board is not a covered service for Level II or Level III HCB alternative behavioral health facilities, therapeutic foster care homes or RSATAs. (Refer to the section on behavioral health services included in Chapter 300, Policy 310, for a listing of services included in the comprehensive service package.)

- **COMMUNITY RESIDENTIAL FACILITIES**

Description. Community residential facilities include:

1. Community residential settings

   a. Adult developmental homes. A home and community based (HCB) alternative residential setting for no more than three members who are age 18 or older

   b. Child development foster homes. A HCB alternative residential setting for no more than three members who are under age 18.

2. Group homes. A residential facility for no more than 6 members.

Community residential settings are licensed by the Arizona Department of Economic Security to provide room, board, personal care, supervision and coordination of habilitation and treatment. Group homes are licensed by Arizona Department of Health Services for health and safety and monitored by the Contractor for programmatic compliance. These facilities provide a safe, homelike family atmosphere that meets the physical and emotional needs of ALTCS members who cannot physically or functionally live independently in the community. ALTCS covers services, except room and board, which are provided to ALTCS members residing in these facilities.

Amount, Duration and Scope. Services include habilitation and personal care and must be provided according to the member's individual service plan. Refer to Policy 1240 in this Chapter for a description of habilitation and personal care.

Other HCBS that may be provided to members residing in a community residential facility include services provided by a home health agency, medical acute care services, supplies and durable medical equipment, transportation and behavioral health services. Refer to Policy 1240 in this Chapter for descriptions of these services and any limitations to ALTCS coverage.

EXHIBIT 1230-1

AHCCCS/ALTCS ALTERNATIVE RESIDENTIAL SETTINGS, SERVICE CODES AND APPLICABLE UNITS OF SERVICE

EXHIBIT 1230-1

AHCCCS/ALTCS ALTERNATIVE RESIDENTIAL SETTINGS, SERVICE CODES AND APPLICABLE UNITS OF SERVICE

ALTERNATIVE RESIDENTIAL SETTINGS	CODE	UNIT
Assisted Living Home	T2031 T2031 TF T2031 TG	Per Diem
Assisted Living Center **Alzheimer's Demonstration Pilot**	T2033 T2033 TF T2033 TG T2033 U1	Per Diem
Adult Foster Care	S5140 S5140 TF S5140 TG	Per Diem
Habilitation – Residential **(used for DD Group Home)**	T2016 T2016 TF T2016 TG _____ T2017	Per Diem _____ 15 Minutes (up to 64 Units)
Level II Behavioral Health Residential	H0018 H0018 TF H0018 TG	Per Diem
Level III Behavioral Health Residential	H0019	Per Diem
Therapeutic Child Foster Home	S5145	Per Diem

Note: TF modifier means Level II
TG modifier means Level III

1240 HOME AND COMMUNITY BASED SERVICES

GENERAL REQUIREMENTS

Home and community based services (HCBS) included in this policy are covered for ALTCS members and provided by AHCCCS registered providers. These services must be ordered/approved by the member's primary care provider (PCP) and/or authorized by the member's case manager. Exhibit 1240-3 provides information regarding those services which require PCP orders and/or those that require case manager authorization. Exhibit 1240-6 provides a table of services, service codes and units for services described in this section, with the exception of therapy services. For more information regarding therapy service codes, consult the most applicable version of the American Medical Association's "Current Procedural Technology" manual and/or the "Health Care Common Procedure Coding System" manual.

The number and frequency of authorized services received by a member is determined through an assessment of the member's needs by the case manager with the member and/or the member's family, guardian or representative, in tandem with the completion of the cost-effectiveness study. Refer to Chapter 1600, Case Management, for detailed information regarding this process. Chapter 1600 also contains information regarding the need for ongoing monitoring visits to assess for the continued appropriateness and accurate provision of services and quality of care. Results of monitoring visits must be documented in the member's casefile by the member's case manager.

Those categories of authorized ALTCS service providers governed by a State regulatory board or agency must maintain a current license or certification through the appropriate State regulatory board or agency. FFS Tribal affiliated providers must meet AHCCCS requirements as attested by the Tribal government and approved by CMS (e.g., home delivered meal provider). Those categories of authorized ALTCS service providers that are not governed by a regulatory board or agency must be certified or approved by a managed care Contractor, or through the AHCCCS Administration for Tribes.

Homemaker, personal care and attendant care agencies are required to perform periodic supervisory visits. The visits are done to assess the employee competency in performing the assigned duties is in a safe manner, as ordered and according to the training the employee has received. Supervisory visits must be documented in the caregiver file.

If services are not provided as authorized, the reasons for the non-provision of services must be documented by the provider in the provider's member casefile. There are distinct timeframes for these visits, as well as instances when the employee must be present and when they do not need to be present.

1. Supervisory Visits Requiring the Employee's Presence

   Some supervisory visits must be done while the employee is providing services, in order to observe the care being given. Supervisory visits completed while the employee is physically in the member's home are required within the first 90 days of the employee's hire date, and annually thereafter, unless otherwise warranted. These visits may be combined with #2 below as determined applicable.

2. Supervisory Visits Not Requiring the Employee's Presence

   The following supervisory visits do not require the presence of the employee at the time of the visit, although these visits may be combined with #1 above as determined applicable. They are as follows:

   a. Attendant Care/Personal Care Services: Supervisory visits for attendant care and personal care services are required in order to speak with the member regarding the quality of care, delivery of services and education of the member about the need to call the agency if concerns develop between supervisory and/or case manager visits. This type of supervisory visit must be initiated not more than five days from the day the initial service provision began (not every time the employee changes). A follow up site visit is required at 30 days. A 60 day visit is required if issues are identified, otherwise visits are required at least every 90 days thereafter (more often as indicated). HHA visits are as prescribed by regulation.

   b. Homemaker Services: Supervisory visits for homemaker services are required in order to speak with the member regarding the quality of care, delivery of services and education of the member about the need to call the agency if concerns develop between supervisory and/or case manager visits. This type of supervisory visit must be initiated not more than five days from the day initial service provision began (not every time the employee changes), but, depending on the nature of the care being performed, that contact can be made by telephone. An on-site visit is required, however, at 30 days from the day service provision began. A 60 day visit would only be required is issues are identified, otherwise, on-site visits are required every 90 days thereafter.

- **ADULT DAY HEALTH CARE SERVICES**

ALTCS covers services provided by adult day health care facilities which are licensed by the Arizona Department of Health Services (ADHS). Services are available for members who are either elderly and/or have physical disabilities who need supervision, assistance in taking medication, recreation and socialization or personal living skills training. Health monitoring and/or other health related services such as preventive, therapeutic and restorative health care services are also covered. Members with developmental disabilities are not eligible for this service.

Amount, Duration and Scope. ALTCS members who reside in their own home may receive adult day health care.

If ALTCS members who reside in an adult foster care home, assisted living home or assisted living center are to receive adult day health care services, special justification is required by the member's case manager and approval by the managed care Contractor or AHCCCS Administration for FFS members. Members residing in a Level II or Level III behavioral health facility are not eligible to receive adult day health care services.

Within the same day, attendant care, home health aide services or personal care services can only be provided by exception with adult day health care.

Specific justification as to the circumstances for the need for one of the above services and adult day health care services must be documented by the case manager and approved by the Contractor for managed care members, or the AHCCCS Administration for FFS members.

Group respite care services may be provided as a substitute when adult day health care services are not available. Group respite care providers are required to comply with the standards and requirements specified in this Policy for respite care.

In order to participate in group respite care, members must be:

1. Continent of bowel and bladder or able to provide self-care

2. Ambulatory, or if wheelchair bound, be self-propelling and need only standby assistance for transfer

3. Able to attend respite programs without the need of medications while in program, or be able to self-administer medications

4. Not in need of any licensed services during program's daily operation, if licensed personnel are not included in the provider's staffing for the group respite program, and

5. Not a danger to himself/herself or others.

- **ATTENDANT CARE**

Description. AHCCCS covers attendant care services provided to ALTCS members. The attendant provides assistance with a combination of services which may include homemaking, personal care, general supervision and companionship. This service enables members who might otherwise be in a nursing facility or HCB alternative residential setting to remain at, or return to, their own home when that environment is not medically contraindicated and when it is cost effective to do so. The intent of attendant care is to initiate strong support for keeping members integrated with their families, communities and other support systems. This service requires involvement from the member and/or the member's family, guardian or representative in decisions related to attendant care provider functions.

Amount, Duration and Scope. Attendant care services are not licensed or certified by a State regulatory board or agency.

Attendant care services are available only to ALTCS members who reside in their own home. However, attendant care services are not limited to the boundaries of the member's home. As indicated in the individualized care plan, the attendant may accompany the member as necessary in order to meet his/her needs in a variety of settings, including, but not limited to, a physician's office, school setting and workplace. Attendant care services are not reimbursable in an adult foster care home, assisted living home, an assisted living center, community residential facility or behavioral health facility as described in Policy 1230 of this Chapter.

Other HCBS may be provided in conjunction with attendant care. However, within a given day, attendant care services may not be provided in conjunction with personal care, home delivered meals and homemaker services without special justification by the case manager and approval by the ALTCS Contractor or AHCCCS Administration for FFS members.

Adult day health care/group respite services are also excluded on days when attendant care is provided unless rationale has been specifically justified by the members case manager, and approved by the ALTCS Contractor or AHCCCS Administration for FFS members.

Under 9 A.A.C. 22, Article 2, the Contractor has the discretion to approve attendant care services temporarily in a "Contractor Out-of-Service Area", in circumstances when it would be of benefit for the member and is cost effective. An example would be for a family caregiver to be paid for accompanying the member while in a "Contractor Out-of-Service Area" in lieu of a nursing facility stay for the member.

Attendant care services are provided in accordance with the member's individualized care plan and include, but are not limited to:

1. Homemaker tasks including cleaning, laundry, food preparation and essential errands such as grocery shopping, securing medical supplies and household items

2. Personal care including bathing, skin care, oral hygiene, toileting, ambulation, grooming, dressing, nail care, use of assistive devices and caring for other physical needs (excluding bowel care that can only be performed or delegated by a licensed registered nurse to a licensed practical nurse) and feeding as necessary

3. General supervision which includes:

   a. Monitoring and companionship for a member who cannot be safely left alone

   b. Assisting with self-administration of medications, and

   c. Monitoring the member's medical condition and ability to perform the activities of daily living.

4. Coordination with the member and/or the member's family, guardian or representative to assure activities and necessary services are provided to meet the objectives of the member's individualized care plan

5. Assistance with recreational/socialization skill development, training in activities of daily living, and

6. Documentation of and communication with the attendant care agency and the member's case manager regarding any decline, improvement or continuing maintenance of the member's condition.

ATTENDANT CARE PROVIDER (CAREGIVER) STANDARDS AND REQUIREMENTS

The provider of attendant care services must comply with the following standards and requirements:

1. Hold current certification of competence in the delivery of attendant care services from the ALTCS Contractor, the ALTCS Contractor's qualified contracting agency or AHCCCS Administration.

2. Successfully completed formal training in the necessary skills to meet certification requirements in personal care, homemaking, toileting, recognition of a change in a member's condition, cardiopulmonary resuscitation and first aid, transfer techniques, knowledge of member rights, disability types and basic nutrition, communication skills and service contract development before providing attendant care services to an ALTCS member.

3. Comply with recommendations and requirements resulting from routine monitoring and supervision by the ALTCS Contractor or subcontracted agency. This is to ensure the competency of the attendant care provider and to assist the member and the attendant in adjusting to working together. All monitoring and supervision assessments must be documented and kept in the attendant care provider's personnel file.

4. Comply with the objectives and methods specified in the member's individualized care plan. The care plan, based on an assessment of the member's level of functioning and need for attendant care and other services, must be developed by the case manager for each member who is to receive attendant care services. The attendant care provider must notify the case manager or designee of any changes in member condition.

5. The following immediate relatives may not provide attendant care:

   a. Spouse

   b. Natural parent *

   c. Adoptive parent *, and

d. Stepparent. *

*Parents may provide attendant care services if the member is 18 years or older or if there are extraordinary circumstances as determined by the ALTCS Contractor or in coordination with the AHCCCS Administration for FFS members.

ATTENDANT CARE PROGRAM MANAGEMENT COMPONENTS

The following criteria applies to ALTCS Contractors who elect to establish and maintain an attendant care component or attendant care agencies with regard to recruitment, selection and training of attendant care worker (ACW) applicants.

1. Interviewing applicants within 14 days of contacting the Contractor or subcontracting agency unless there are extenuating circumstances that would reasonably prevent this process

2. Screening of ACW applicants, including contacting three references, one of which must be a former employer. This process must also incorporate evaluation of the appropriateness of allowing the member's immediate relatives to provide attendant care for them.

3. Providing training, evaluation of competency, and certification that the ACW applicant is knowledgeable and/or skilled in areas including, but not limited to:

   a. Time management

   b. Assisting the member in toileting

   c. Assisting the member in transferring

   d. Basic nutrition and meal preparation

e. Awareness of the member's current condition and need to ensure timely reporting of changes and needs to the ACW supervisor

f. Certification in cardiopulmonary resuscitation (CPR) and first aid

   i. Training in CPR and first aid must be provided or sponsored by a nationally recognized organization (e.g., American Red Cross, American Heart Association, etc.)

   ii. Training sessions must be in person in order for the participant to return demonstrate learned skills such as mouth-to-mouth resuscitation and chest compressions. Web-based training without the benefit of on-site return demonstration of skills is not acceptable.

g. Homemaking tasks

h. Member rights

i. Assisting the member in personal care

j. Providing care based on the member's established service plan within the limitations of attendant care services

k. Types of disabilities

l. Verbal and written communications, and

m. Cultural diversity and sensitivity training.

4. Matching the skills of certified ACWs with each ALTCS member's needs for attendant care, as well as the member's personal preferences. The member and/or member representative should be offered the opportunity to interview and select an appropriate ACW. The agency needs to be available to assist in this process as requested. The entire selection process should occur as expeditiously as possible subsequent to the referral. The process also includes initiating a written agreement between the member and/or member representative and the ACW that delineates the responsibilities of each.

5. Providing any necessary specialized training or technical assistance in order for a selected certified ACW to provide necessary services to the member

6. Conducting continuing education/training sessions for certified ACWs on at least an annual basis

7. Providing necessary training for the member and/or member representative in evaluation of the ACW and effectively managing complex situations (i.e., grievances, thefts or terminations)

8. Providing supervisory visits as described in the "General Requirements" section of this policy (Policy 1240)

9. Verifying the delivery of attendant care services, including methodologies to discourage falsification of records, and providing payment for such services within agreed upon timeframes

10. Maintaining records which demonstrate:

    a. The number of ACW training classes given (as required in 3. above), the location and date each class was held, the number of ACW trainees enrolled for each, as well as the number of ACW trainees who completed the classes

    b. The number of hours authorized and spent in all other management activities specified above, and

    c. Records of ACW work verification and payment that are retained according to 9 A.A.C. 28, Article 5

11. An attendant may be exempted from the initial training and certification process if the ACW meets one of the following:

    a. Is currently employed by an established home health agency to provide caregiving services

    b. Has a current nursing license

    c. Has received registered certification as a nursing assistant or obtained certification from a training program for attendant care

    d. Has received training from a certified agency that submits a letter of competency to the Contractor or subcontracted attendant care management agency. The certifying agency must be approved by the Contractor

    e. Passes a competency exam administered by the Contractor or subcontracted attendant care management agency. The competency exam must be approved by the Contractor.

- **BEHAVIORAL HEALTH SERVICES**

Refer to Policy 1250 in this Chapter and Appendix G in this Manual for information regarding behavioral health services available to ALTCS members residing in their own home, an institutional setting or an approved HCB alternative residential setting.

- **EMERGENCY ALERT SYSTEM**

Description. AHCCCS covers monitoring devices/systems for ALTCS members who are unable to access assistance in an emergency situation and/or live alone.

Amount, Duration and Scope. In order to be approved to receive/use emergency alert system equipment, the following five criteria must be met:

1. The member must have the ability to use and operate the system

2. The member does not have reliable/available emergency assistance on a 24 hour basis

3. Lives alone in the member's own home or is alone for intermittent periods of time without contact with a service provider, family members or other support systems, leaving the member at risk. If emergency alert system equipment is to be provided for members residing in a HCB alternative residential setting, it must be justified by the case manager and approved by the managed care Contractor or the AHCCCS Administration for FFS members.

4. The assessment of the member's medical and/or functional level documents an acute or chronic medical condition which is not improving, and

5. The cost effectiveness study completed by the member's case manager shows that the total cost of the emergency alert system equipment is within current guidelines.

Emergency alert system equipment may not be provided without orders from the member's primary care provider. The member's case manager must authorize the service initially, and each time the member's service plan is reviewed in order to continue the service.

Units are reported as emergency alert system, either purchased or rented, and a monthly services/maintenance fee.

There are no restrictions regarding other HCB services that may be provided in conjunction with emergency alert system services.

- **HABILITATION SERVICES**

Description. AHCCCS covers habilitation services for ALTCS members through its managed care Contractors or the FFS program. The service known as "Day Treatment and Training", also known as developmentally disabled daycare, is included under the habilitation services. Services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in HCB settings. The services include the provision of training in independent living skills or special developmental skills, orientation and mobility training, sensory-motor development, behavioral management and supported employment. Physical therapy, occupational therapy, and speech therapy may be provided in conjunction with habilitation therapies as described in this section.

Amount, Duration and Scope. Habilitation services may be provided in two ways: 15 minute increments or a per diem rate.

Habilitation providers must be certified by Arizona Department of Economic Security/Division of Developmental Disabilities and registered as an AHCCCS provider prior to rendering services. Services may be provided to ALTCS members who reside in their own home, an HCB alternative residential setting or a Level III behavioral health facility. The number and frequency of services is determined through the cost effectiveness study conducted by the case manager and specified in the member's service plan. Members may not receive habilitation services while residing in a Level I or Level II behavioral health facility.

Other HCBS may be provided in conjunction with habilitation. Habilitation providers may carry out activities designed by a therapist as part of the daily routine. There is no duplication to have both a habilitative therapy and a habilitation service on the same day. AHCCCS encourages a therapist to train primary caregivers (paid and unpaid) to carry out the therapy activities within the normal routine of the member.

- **HOME DELIVERED MEALS**

Description. AHCCCS covers home delivered meals provided to ALTCS members who are elderly and/or have physical disabilities (E/PD) and reside in their own home, but are in jeopardy of not consuming adequate nutritious food to maintain good health. Members with developmental disabilities are not eligible for this service.

Amount, Duration and Scope. One unit of service equals one meal. No more than one unit of service may be provided to an E/PD member for any given day. E/PD members residing in a HCB alternative residential setting are not eligible for this service. Members may not receive home delivered meals within the same day that attendant care is provided, unless the case manager provides special justification and it is approved by the managed care Contractor or the AHCCCS Administration for FFS members. There are no other restrictions regarding other HCB services that may be provided in conjunction with home delivered meal services.

All providers that prepare home delivered meals must have documentation that they are currently in compliance with local fire and sanitation codes and regulations and, where applicable, have a food handling/food preparation operating permit issued by local regulatory authority.

Each person preparing or delivering meals must successfully complete training regarding food preparation and proper storage to ensure maximum nutrition and minimum spoilage. Training must be documented in each individual's personnel file.

All food contributions must be received from a source approved by Arizona Department of Health Services and meet required inspection standards. For example, venison may be received from the Arizona Department of Game and Fish after a meat inspection indicates it meets health standards.

Providers of home delivered meals must comply with the following standards:

Menus must be:

1. Planned for a minimum of four consecutive weeks and rotated three times before changing menus for another four weeks

2. Filed and available for audit inspection at the service provider's place of business for at least one year after the meals have been served

3. Written in the dominant language or languages of the participant group. The menu must reflect food choices to accommodate ethnic and cultural preferences when necessary.

4. Approved by the service provider's registered dietitian or nutritionist prior to posting

5. Adhered to as written. Substitutions must be approved by a registered dietitian or nutritionist and must be documented on the menu.

6. Planned as hot meals. Occasionally a cold meal may be planned to provide variety and change, and to accommodate the seasons of the year, and

7. Prepared considering the availability of foods during seasons when they are most plentiful.

Meal requirements:

1. Each meal must contain at least one-third of the current Recommended Daily Allowance (Dietary Reference Intakes – DRIs) of nutrients as established by the Food and Nutrition Board of the National Academy of Science-National Research Council. Standards may be reviewed at the following Web site: http://iom.edu/CMS/3788/4574.aspx . In addition, meals must adhere to current dietary recommendations of sugar, salt and fat intake.

2. All meals must be packaged and delivered in a safe and sanitary manner.

3. All meals must be delivered to the member directly, e.g., not left on doorsteps, mailboxes or porches.

4. Frozen/dried foods for meals are acceptable for use on days when no delivery is available, provided that:

   a. The meal and meal preparation meet all the standards within this policy

   b. It is verified and documented in the case record that the member has the ability to properly store and prepare frozen or dried meals, and

   c. If a member is to receive more than one frozen meal per delivery, the reason for receipt of multiple meals must be documented in the member's case record.

5. Upon receipt of a written order from the member's primary care physician or attending physician, meals must be prepared and served for members who require a therapeutic diet, such as diabetic or sodium-restricted diets. All special diets must be approved by a registered dietitian or nutritionist.

6. The member's signature and delivery date of each meal must be obtained and maintained in a central file. If a member is physically or mentally unable to sign his/her own name, it must be noted in the member's file and one of the following procedures must be followed:

   a. The member may sign with his/her mark "X," witnessed by a spouse, relative, friend, or the home delivered meal aide. The witness must then write his/her name and relationship, or

   b. Another person (conservator, spouse, relative or friend) may sign for the member only if so designated within the member file.

Additional Requirements:

1. Case records must be maintained in locked files to ensure confidentiality and kept in the provider's offices

2. If services are not provided, reasons for non-provision are recorded

3. Printed educational materials regarding a variety of nutrition and health-related topics must be provided by the home delivered meals provider at least two times per quarter to members who receive these services, and

4. The provider must respond within three weeks to written concerns/reports from the provider's consulting registered dietitian or nutritionist and must initiate corrective action.

   a. A registered dietitian is defined as a person who meets all the requirements for membership in the American Dietetic Association, has successfully completed the examination for registration and maintains the continuing education requirements.

   b. A nutritionist is defined as a person who has a bachelor's or master's degree in Food and Nutrition.

- **HOME HEALTH SERVICES**

Description. AHCCCS covers medically necessary home health services provided to ALTCS members by a home health agency (HHA) licensed by the Arizona Department of Health Services and Medicare certified or under circumstances as described in policy, by a state licensed home health agency or by an independent registered nurse. Covered services include home health aide services, home health skilled nursing visits, private duty nursing, medically necessary supplies and therapy services. Exhibit 1240-1 provides a listing of medical supplies included in FFS home health nursing visits.

Amount, Duration, and Scope.

Home Health Agency Services

ALTCS members who reside in their own home, an adult foster care home, or a Level II or Level III behavioral health facility may receive HHA services. Members residing in a Level I behavioral health facility are not eligible to receive HHA services.

Home health skilled nursing services may be provided to members residing in an assisted living facility when skilled nursing services are not included in the facility per diem rate. The managed care Contractor or AHCCCS Administration may negotiate rates with the facility that includes skilled nursing services.

Refer to Exhibit 1240-2 for a matrix of services that may be provided by home health nurses.

HHA services may not be provided on the same day that a member receives adult day health services without special justification by the member's case manager and approval by the managed care Contractor or the AHCCCS Administration for FFS members. Also, if a home health aide is authorized by the case manager in the member's service plan to provide personal care and/or homemaker services as a part of HHA services, these services must not be provided separately by a homemaker/personal care provider on the same day.

HHA services must be provided by a licensed/Medicare certified home health agency. There are circumstances, however, when a non-Medicare certified/State licensed HHA or an independent Registered Nurse may be utilized. In those instances, the requirements of 42 CFR, Part 440, Section 70, apply. Under these standards, only a RN is allowed to provide skilled nursing services. A non-Medicare certified HHA or an independent RN can provide services in the following circumstances:

1. Home health nursing services are needed in a geographic area not currently served by a Medicare certified HHA.

2. The Medicare certified HHA in a geographic area served does not have adequate staff to provide the services or meet the needs of the ALTCS member(s), or

3. The Medicare certified HHA is not willing to provide services to/or contract with the Contractor.

When a non-Medicare certified HHA or independent RN is used, in the allowed circumstances noted in this section, the following applies:

1. Home Health Agency

   a. The Contractor must contract with a state licensed home health agency.

   b. The Contractor must maintain documentation of at least one of the three circumstances previously referenced.

2. Independent RN

   a. The Contractor must maintain documentation of at least one of the three circumstances referenced in this section.

   b. Independent RNs providing home health care under these circumstances must receive written orders from the member's primary care provider (PCP) or physician of record, and are responsible for all documentation of member care. The RN must have completed an orientation to clinical and administrative recordkeeping by a nurse approved by, or contracted with, a managed care Contractor prior to providing skilled home health nursing. For FFS members, the attending physician must monitor the independent RN.

c. Managed care Contractors who employ independent nurses to provide home health skilled nursing must develop oversight activities to monitor service delivery and quality of care provided by the independent RN.

d. Potential new providers of independent RN home health skilled nursing must submit, in writing, three references from persons other than family to the Contractor or AHCCCS Administration. If the RN is hired, all references must be contacted, and the results documented in the employee's personnel record.

Home Health Intermittent Nursing Services

1. Home health intermittent nursing services must be ordered by a physician. Services must be provided by a RN, or a LPN under the supervision of an RN or physician. LPNs may only provide intermittent nursing services if they are working for a Medicare-certified HHA.

2. Home health intermittent nursing services are implemented through the member's individualized care plan. The plan must be reviewed by a physician every 62 days (bimonthly) and must be authorized and monitored by the member's case manager as specified in Chapter 1600 of this Manual.

3. Skilled nursing assessments required pursuant to criteria and guidelines specified under service plan monitoring functions included in Chapter 1600, Standard XI of this Manual must be performed by skilled nursing staff of a Medicare certified and/or State licensed HHA or independent RN. The following are examples of conditions requiring a skilled nursing assessment: pressure ulcers, surgical wounds, tube feedings, pain management and/or tracheotomy.

4. The service provider is required to submit written monthly progress reports to the member's PCP or attending physician regarding the care provided to each assigned member. Refer to Chapter 1600, Standard XI, for case management quarterly consultation and documentation requirements.

5. A unit of home health intermittent nursing is one hour.

Home Health Private Duty Continuous Nursing Services

Home health private duty nursing services may be provided for ALTCS members who reside in their own home. Private duty nursing services are provided on a continuous basis as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of intermittent nursing care and when determined to be cost-effective.

Home health private duty nursing services must be ordered by a physician and provided by an RN or a LPN in accordance with 42 CFR 440.80. If the services are furnished by an LPN, he/she must provide the services under the supervision and direction of an RN or physician. Services may be provided through a State licensed/Medicare certified HHA, a State licensed HHA (if a Medicare certified HHA is not available, per criteria previously noted in this Policy) or by an independent RN/LPN.

An independent RN/LPN providing home health private duty service must receive written orders from the member's PCP or physician of record and are responsible for all documentation of member care. Contractors who employ independent nurses to provide private duty nursing must develop oversight activities to monitor service delivery and quality of care provided by the independent RN/LPN. Contractors must also provide a mechanism for ensuring backup to the independent private duty nurse.

The unit of private duty nursing service is 60 minutes.

Home Health Aide

1. Home health aide services must be ordered by a physician and are implemented through the member's individualized care plan developed by the HHA provider and may only be provided on an intermittent basis. The plan must be reviewed by a physician every 62 days (bimonthly) and authorized/monitored by the member's case manager as specified in Chapter 1600 of this Manual.

2. Home health aides provide nursing and nursing-related services under the direction and supervision of a RN. The services include monitoring of a member's medical condition, health maintenance or continued treatment services and activities of daily living.

3. The unit of home health aide services is one visit. A visit is usually one hour, but may be greater or lesser depending on the time it takes to render the procedure(s). Visits include at least one of the following components, but are not limited to providing services to the member as follows:

   a. Assessing the health and functional level, and assistance with the development of the HHA plan of care for the member

   b. Monitoring and documenting of vital signs, as well as reporting results to the supervising RN or physician

   c. Providing personal care

   d. Assisting with bowel, bladder and/or ostomy programs, as well as catheter hygiene (does not include catheter insertion)

   e. Assisting with self-administration of medications

   f. Assisting members with eating, if required, to maintain sufficient nutritional intake, and providing information about nutrition

   g. Assisting with routine ambulation, transfer, use of special appliances and/or prosthetic devices, range of motion activities or simple exercise programs

   h. Assisting in activities of daily living to increase physical mobility

   i. Teaching members and families how to perform home health tasks, and

   j. Referring members for appropriate services when the exhibit medical or social problems during the course of service delivery.

Home Health Therapy Services

Refer to the section of Policy 1250 of this Chapter entitled “Therapies” that addresses physical therapy, occupational therapy, respiratory therapy and speech therapy for detailed information regarding these services.

- **HOMEMAKER SERVICES**

Description. AHCCCS covers homemaker services provided through a Contractor or AHCCCS Administration to ALTCS members who require assistance in the performance of activities related to household maintenance. The service is intended to preserve or improve the safety and sanitation of the member's living conditions and the nutritional value of food/meals for the member. In addition, this service enables members who would otherwise be in a nursing facility or HCB alternative residential setting to remain at, or return to, their own home if this environment is not medically contraindicated and is cost effective.

Amount, Duration and Scope. Homemaker services are available only to ALTCS members who reside in their own home. Members residing in HCB alternative residential settings described in Policy 1230 are not eligible to receive homemaker services.

Within the same day, homemaker services cannot be provided in conjunction with attendant care, or home health aide services that encompass homemaker tasks, without special justification from the member's case manager that is approved by the managed care Contractor or the AHCCCS Administration for FFS members. There are no restrictions on other services to be provided in conjunction with homemaker services on any given day.

Licensure is not required for homemaker service providers, however, they must meet qualification standards/requirements set by the Contractor and following AHCCCS policy. Homemaker service providers must also register as AHCCCS providers.

Each homemaker must hold current certification in cardiopulmonary resuscitation and First Aid, have appropriate skills to meet the needs of each member assigned to the homemaker and submit at least three references. All references and skills must be verified and documented in the provider's personnel file.

One unit of homemaker service is 15 minutes. The number and type of homemaker services must be approved by the member's case manager and provided in accordance with the member's service plan. Homemaker services include, but are not limited to:

1. Cleaning tasks necessary to attain and maintain safe and sanitary living conditions for the member and pest control services (on a per diem basis)

2. Meal planning, food preparation and storage tasks necessary to provide food/meals that meet the nutritional needs of the member

3. Laundry tasks, such as laundering the member's clothing, towels and bed linens

4. Shopping for items such as food, housecleaning and laundry supplies and personal hygiene supplies

5. Other household duties and tasks, as included in the member's individualized care plan that are necessary to assist the member. This may include hauling water or bringing in wood or coal and indicated by the member's environment, and

6. For members who exhibit additional medical or social problems, or changes occur in existing conditions during the course of service delivery, the homemaker provider is responsible for informing his/her agency, and/or the case manager, of these things.

- **HOME MODIFICATIONS**

Description. AHCCCS covers physical modifications to the home (as determined through an assessment of the ALTCS member's needs and identified in the member's care plan) that enable the member to function with greater independence in the home and that have a specific adaptive purpose.

Home modifications may be provided to members residing in a home as defined in 9 A.A.C. 28, Article 1 ("A residential dwelling that is owned, rented, leased or occupied by a member…A home is not a facility, a setting or an institution or a portion of any of these that is licensed or certified by a regulatory agency of the State…" If the member does not own the home, the owner of the home must approve the modifications. No Title XIX funds may be used to return a home to its pre-modification state. Home modification is not available to members living in alternative residential settings.

If is recommended that alternatives be considered prior to the authorization of a home modification project. Alternatives considered must be those that would assist in maximizing independence. For instance, giving the member bed baths in lieu of making the bathroom accessible would not be a good alternative to home modification. Examples of alternatives include:

1. Use of another accessible bedroom, bathroom or entry if the current arrangement is inaccessible for the member

2. Use of durable medical equipment (e.g., transfer bench), and

3. Other resources. The member's needs must be met in a timely manner, even when coordinating with other sources for the provision of this service.

Amount, Duration and Scope.

1. In order to be covered, the home modification must be medically necessary, and may deter the risk of an increase in existing home and community based services or institutionalization.

   Examples of specific exclusions include:

   a. Modifications of the home that are of general utility to the household, or that are not of direct medical benefit to the member, and

   b. General maintenance, home improvements or home repair. These are considered to be the responsibility of the homeowner and are not covered by AHCCCS.

   Note: Home modifications have limited benefits and cannot be expected to alleviate all risk of injury or make every task easier or more convenient.

2. An assessment and documentation of the member's needs for home modifications must include the following, as appropriate:

   a. PCP or attending physician order

   b. Documentation to support medical necessity, including an assessment of the home modification's impact on the member's ability to independently perform activities of daily living (ADLs). If the home modification will also assist a caregiver in meeting the ADL needs of the member, this documentation must be included.

   c. An assessment by a qualified professional, usually an occupational or physical therapist. An assessment by a certified environmental access consultant (CEAC) can be used in lieu of an assessment from an occupation or physical therapist. In the absence of assessment by a qualified professional, the Contractor's medical Director or physician designee must review the request.

   d. At least two competitive bids (cost estimates) from qualified providers/building contractors for each home modification project for comparison of costs and project options are recommended.

   e. FFS case managers must also submit the completed Home Modification Request/Justification Form. Refer to Exhibit 1240-4 for a copy of the required form.

3. Under 42 CFR 438.210, the managed care Contractor must approve or deny requests for home modifications within 14 calendar days of the request. The Contractor may extend an additional 14 calendar days when there is justification that additional information is necessary for the determination of the request and the extension is in the member's best interest, absent extenuating circumstances. The Contractor must notify the member of the intent to extend the timeframe. The Contractor may not exceed 90 days from the date of the approval for finalizing the specifications and completing the project.

   Denial of a home modification must be signed by the Contractor Medical Director or physician designee.

4. Requests for approval of home modifications for ALTCS FFS members must be submitted to the AHCCCS Division of Fee for Service Management, Prior Authorization Unit, and prior authorized by the Manager of the PA Unit or designee. A written decision regarding approval or denial of the service may be expected within 30 days from receipt of a properly completed request.

5. Home modifications must be performed by a residential contractor as defined in A.R.S. §32-1101 et seq, and in accordance with applicable State or local building codes. Tribal Contractors may use a building contractor who has been certified by the Tribal Authority for home modifications on the reservation. All residential or building contractors must be registered AHCCS providers.

   Examples of modification that may be covered include, but are not limited to:

   a. Installation of one ramp, including handrails, and necessary threshold modification, to facilitate barrier-free member access to their home

   b. Widening of doorways to allow a member in a wheelchair access to essential areas of their home

c. Modification of one bathroom to allow member access and/or increased independence in bathing and toileting functions. For example, roll-in showers, wall-hung or other wheelchair accessible sinks, re-positioning of existing fixtures for adequate movement within the bathroom, and specialized toilets to allow for easier transfers, and

d. Removal of flooring cover for ease of access and replacement with suitable flooring. This does not include removal of carpet for hygiene purposes.

The cost of home modifications may include refinishing the area, such as drywall finishing and painting, and general cleanup of construction debris from the site after completion of the project. This does not include items for aesthetic purposes. If the building contractor must travel a distance of more than 30 miles one way to the member's home in order to complete the project, mileage expenses may also be included in the cost of the service. Associated costs such as those noted in this paragraph must be within reasonable limits.

- **HOSPICE SERVICES**

  Refer to Policy 1250 in this Chapter for information regarding hospice services available to ALTCS members residing in their own home, an institutional setting or an approved home and community based alternative residential setting.

- **MEDICAL SUPPLIES, EQUIPMENT, APPLIANCES AND CUSTOMIZED DURABLE MEDICAL EQUIPMENT**

  Description. Medical supplies, equipment, appliances and customized durable medical equipment (DME) are covered as specified in Chapter 300, Policy 310, provided to ALTCS members and are the same as those provided to members enrolled in the acute care program. Purchase, rental, replacement and/or repair of DME are included.

  Amount, Duration and Scope. These services require orders from the member's primary care provider (PCP) or attending physician, and prior authorization from the member's case manager, ALTCS managed care Contractor or AHCCCS Administration for FFS members. Medical supplies, equipment, appliances and customized DME services may be provided to ALTCS members residing in their own home, or any ALTCS approved home and community based (HCB) alternative residential setting, and in conjunction with any HCBS. Customized DME and medical equipment may also be provided in an institutional setting upon orders from the member's PCP and approval by the ALTCS member's case manager and managed care Contractor or the AHCCCS Administration for FFS members.

  Refer to Chapter 100 for the definition of customized DME.

  Refer to Chapter 400, Policy 430, for criteria related to coverage of incontinence briefs for members under the age of 21.

  Note: A physician's order is not required for repair or replacement of identical DME.

- **NUTRITIONAL ASSESSMENTS AND NUTRITIONAL THERAPY**

Nutritional assessments and nutritional therapy apply to all ALTCS members whose health status may improve or be maintained with nutrition intervention. Specific policy requirements/locations are as follows:

1. Chapter 400, Policy 430, EPSDT for members 20 years of age and under

2. Chapter 300, Policy 320, medical foods for members with specific metabolic diseases, and

3. Policy 1240, Nutritional Assessments and Nutritional Therapy, as follows, for ALTCS members 21 years of age and older.

Note: Refer to Appendix I for charts estimating body mass index (BMI).

Nutritional assessments – Nutritional assessments are conducted to assist ALTCS members, 21 years of age and older, whose health status may improve with nutrition intervention. ALTCS covers the assessment of nutritional status as determined necessary and as a part of health risk assessment and screening services provided by the member's primary care provider (PCP). Nutritional assessment services provided by a registered dietitian are also covered when ordered by the member's PCP. To initiate the referral for nutritional assessment, the PCP must comply with managed care Contractor protocols or AHCCCS Administration protocols for FFS members.

Nutritional Therapy – ALTCS covers nutritional therapy on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

1. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by J-tube, G-tube or N/G tube.

   Refer to specific managed care Contractor for managed care members or to Chapter 800 of this Manual and the AHCCCS PA Unit for FFS members for information on prior authorization requirements.

2. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength.

   Refer to specific managed care Contractor for managed care members or to Chapter 800 of this Manual and the AHCCCS PA Unit for FFS members for information on prior authorization requirements.

3. Commercial Oral Supplemental Nutritional Feedings: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

   a. Authorization from the member's managed care Contractor or the AHCCCS Administration for FFS members is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. Authorization is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

   b. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria specified in this policy. The PCP or attending physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" (Exhibit 1240-5) to obtain authorization from the member's case manager and managed care Contractor or the AHCCCS Administration for FFS members, and

c. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or attending physician, or through consultation with a registered dietician. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

4. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:

   a. The member has been at or below the 10th percentile on a nationally recognized height and weight or Body Mass Index (BMI) chart (see Appendix I) for their age and gender for three months or more. Height and Weight charts and BMI calculators can be found at various sites on the Internet, including the Centers for Disease Control and the National Institutes of Health.

   b. The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment).

   c. The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

   d. Absorption problems are evidenced by emesis, diarrhea, dehydration, electrolyte imbalance, significant weight loss, etc. and intolerance/allergy to current food products has been ruled out, and

   e. The member requires nutritional supplements on a temporary basis due to an emergent condition, i.e., pre and/or post-hospitalization for surgical procedures or medical condition that is likely to cause weight loss or nutritional stress. (Authorization is not required for the first 30 days.)

Contractors must develop guidelines for use by the PCP in providing the following:

1. Information necessary to obtain PA for commercial oral nutritional supplements

2. Encouragement and assistance to the member and/or caregiver in weaning the member from the necessity for supplemental nutritional feedings, including consultation by a licensed dietician when determined medically necessary, and

3. Education and training, if the member and/or caregiver elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blenderized or specially prepared for the member.

Contractors are responsible for the appropriate transitioning of a member who is receiving nutritional therapy to or from another Contractor, or another service program.

Refer to Chapter 500, Policy 520 for more information related to transitioning members.

- **PERSONAL CARE**

Description. AHCCCS covers personal care services to ALTCS members who require assistance to meet essential personal physical needs and who reside in their own home. This service enables members who would otherwise be in a nursing facility or HCB alternative residential settings to remain at, or return to, their own home if not medically contraindicated and is cost effective.

Amount, Duration and Scope. Personal care services are available to ALTCS members who reside in their own home. Personal care services are not a reimbursable service in HCB alternative residential settings as described in Policy 1230.

Within the same day, personal care services can only be provided by exception with the following services:

1. Attendant care

2. Home health aide services, or

3. Adult day health care or group respite.

Specific justification as to the circumstances for the need for the personal care service and one of the above services must be documented by the case manager and approved by the Contractor for managed care members or the AHCCCS Administration for FFS members. There are no restrictions on other services to be provided in conjunction with personal care services on any given day.

Licensed medical personnel are not required to provide these services. Provision of services is monitored by the member's case manager. The hiring agency is responsible for assuring that employees providing services to ALTCS members are in compliance with Contractor standards and requirements and AHCCCS policy for personal care services.

Personal care providers must hold a current certification in cardiopulmonary resuscitation and first aid, have appropriate skills and training to meet the needs of each member assigned to them and submit three letters of reference. All references, skills and training must be verified and documented in the employee's personnel file when working for an agency. Personal care providers must follow the member's individualized care plan as approved by the case manager.

One unit of service equals 15 minutes and includes, but is not limited to, the following types of services:

1. Assisting members with bathing, feeding, skin care, oral hygiene, toileting, ambulation, transferring, grooming, dressing, nail care, use of assistive devices, use of special appliances and/or prosthetic devices, and caring for other physical needs (excluding bowel care that can only be performed or delegated by a licensed registered nurse to a licensed practical nurse as necessary).

2. Encouraging family support and training caregivers, as appropriate, to meet objectives of the member's individualized care plan, and

3. For members who exhibit additional medical or social problems, or changes in existing conditions during the course of service delivery, the personal care provider is responsible for informing his/her agency and/or the case manager of these changes.

- **RESPITE CARE**

  Refer to Policy 1250 in this Chapter for information regarding respite care available to ALTCS members residing in their own home or an approved home and community based alternative residential setting.

- **THERAPIES**

  Refer to Policy 1250 in this Chapter for information regarding therapy services available to ALTCS members residing in their own home, an institutional setting or an approved home and community based alternative residential setting.

- **TRANSPORTATION**

  In addition to the transportation services described in Chapter 300, Policy 310 of this Manual, ALTCS also covers companion services for members who need escort care to and from medical appointments. The service may be provided when members are unable to be safely transported or safely left alone for medical appointments.

  Companion services may be provided to members residing in their own home, alternative residential setting and/or NF. A unit of service is 15 minutes or as per diem. The service may be provided by an attendant, CNA or other individual knowledgeable about the member's needs. A companion or provider must hold a current certification in cardiopulmonary resuscitation and first aid, have appropriate skills and training to meet the needs of the member assigned to them and submit three letters of reference. All references, skills and training must be verified and documented in the employee's personnel file when working for an agency.

EXHIBIT 1240-1

MEDICAL SUPPLIES INCLUDED IN FEE-FOR-SERVICE HOME HEALTH NURSING VISITS

EXHIBIT 1240-1

MEDICAL SUPPLIES INCLUDED IN FFS HOME HEALTH NURSING VISITS

The following supplies are included in the FFS Home Health Nurse visit rate. Durable medical equipment should not be included in the visit rate. This list is not all-inclusive and its purpose is as a general reference only.

Adhesive spray
Adhesive tape
Antiseptics
Bandage, cling type 6”
Colostomy care
Cotton balls, non-sterile
Cotton balls, sterile
Diabetic daily care
Diabetic diagnostics
Dressing, N-Adhering W/adhve 2X3”
Dressing, transparent
Gauze bandage roll 1” X 10 Yds.
Gauze pads, sterile
Gauze pads, sterile 4X4
Gauze pad, sterile w/gel ½” X 72”
Gauze pad, sterile w/gel 6X 36”
Gauze sponges, non-Sterile 4X4
Gloves, plastic disposable
Glucose care starter kit
Glucose reagent strips
Hydrogen peroxide
Iodoform packing ½” X 5 Yds.
Isopropyl alcohol swabs
Lancets
Lubricating jelly, 1 oz.
Packaging gauze, plain ¼” X 5 Yds.
Petroleum jelly, 1 oz.
Petroleum jelly gauze 1” X 8”
Syringes
Syringes/needles
Syringes/needles Ea. (KDI)
Tape, cloth 2” X 10 yds.
Tape, paper 1” x 5 yds.
Tape Plastic 1” X 5 yds.
Tape, standard adhve 2” X 5 yds.
Tape, standard adhve 1 ½” X 10 yds.
Tape, waterproof adhve 1 ½” X 5 yds.
Tape, waterproof adhve 1”
Urine test strips
Wood applicator w/cotton tips

EXHIBIT 1240-2

HOME HEALTH SKILLED NURSING / PRIVATE DUTY NURSING SERVICES

EXHIBIT 1240-2

HOME HEALTH SKILLED NURSING/PRIVATE DUTY NURSING SERVICES

		Home Health Nurse (Intermittent)	Private Duty Nurse (Continuous)
Registered Nurse (RN)	Medicare Home Health Agency (HHA)	RN Intermittent visit - Certified HHA	RN Continuous - Certified HHA
	Non-Certified HHA	RN Intermittent visit - Non-certified HHA	RN Continuous - Non-certified HHA
	Independent Nurse	RN Intermittent Visit - HH Nurse/Independent	RN Continuous - HH Nurse/Independent
Licensed Practical Nurse - LPN	Medicare HHA	LPN Intermittent Visit - Certified HHA	LPN Continuous - Certified HHA
	Non-Certified HHA	N/A	LPN Continuous - Non-certified HHA
	Independent Nurse	N/A	LPN Continuous HH Nurse/Independent

Home Health Nurse (HHN) [intermittent]

- If services are provided through a Medicare certified Home Health Agency (HHA), a RN or LPN may provide the service.
- If a Medicare certified HHA is not available, the service can only be provided by a RN.
- A LPN may not provide the HHN service through a non-certified HHA or as an independent nurse.

Private Duty Nurse (PDN [continuous])

- PDN service may be provided by a RN or LPN through either a Medicare Certified HHA, a licensed non-certified HHA or by an independent nurse.

Note: Supervision of an LPN by a RN or physician is always required.

EXHIBIT 1240-3

AUTHORIZATION OF HOME AND COMMUNITY BASED SERVICES

EXHIBIT 1240-3

AUTHORIZATION OF HOME AND COMMUNITY BASED SERVICES

Services provided to Arizona Long Term Care System (ALTCS) members receiving home and community based services (HCBS) require authorization by the Contractor, the member's Primary Care Provider (PCP) and/or the AHCCCS Administration (AHCCCSA) as follows:

SERVICE	PCP ORDERS (ALTCS Contractor for enrolled members)		AHCCCSA PRIOR AUTHORIZATION (FFS Members Only)	CONTRACTOR SERVICE AUTHORIZATION	
	E/PD	DD	E/PD	E/PD	DD
Acute hospital admission (Non-Medicare admission)	X	X	X	X	X[3]
Adult Day Health Services				X	N/A
Attendant Care				X	X
Behavioral Health Services	X[1]	X[1]		X	X[4]
DME/Medical Supplies	X	X	X[2]	X	X[3]
Emergency Alert	X	X		X	X
Habilitation				X	X
Home Delivered Meals		N/A		X	N/A
Home Health Agency Services	X	X		X	X
Home Modifications	X	X	X	X	X
Homemaker Services				X	X
Hospice Services (HCBS and Institutional) [Non Medicare]	X	X		X	X
ICF/MR	N/A	X		N/A	X
Medical Care Acute Services	X	X	X	X	X[3]
Nursing Facility Services	X	X		X	X
Personal Care				X	X
Respite Care (in-home)				X	X
Respite Care (Institutional)	X	X		X	X
Therapies	X	X		X	X[3]
Transportation				X	X

[1] Refer to Policy 1620, #7 "Behavioral Health Standard"

[2] DME over $500 for FFS members requires approval from AHCCCS/Division of FFS Management/Prior Auth. Unit, via the Tribal case manager. DME from $300 to $499 requires approval from the FFS case manager.

[3] DDD contracted health plans authorize.

[4] ADHS/BHS authorizes through its subcontracted RBHAs.

Revision Dates: March 2006, November 2004, October 2001, June 2000

EXHIBIT 1240-4

AHCCCS/ARIZONA LONG TERM CARE SYSTEM
FFS HOME MODIFICATION REQUEST/JUSTIFICATION FORM

EXHIBIT 1240-4
AHCCCS/ALTCS FFS HOME MODIFICATION REQUEST/JUSTIFICATION FORM

SECTION A. TO BE COMPLETED BY REQUESTOR. ATTACH ALL REQUIRED DOCUMENTATION.

Send completed form to:	**Tribal Contractor** _____
AHCCCS Division of Fee for Service Mgmt Prior Authorization 701 E. Jefferson, Mail Drop 8900 Phoenix, AZ 85034 Fax: (602) 256-6591	**Case Manager** _____ **Address** _____ **Phone** _____ **Signature** _____

1. Member's Name _____ DOB _____ AHCCCS ID# _____

2. Member's Address _____ City _____

3. Diagnosis _____
(Related to need)

4. PCP's Information _____ _____ Provider ID # _____
(Attach PCP's Order) PCP Name Phone #

5. Member resides in (check one): HOME Own? _____ Or Rent? _____ OTHER (specify) _____

6. **CURRENT ADL STATUS** _____

7. **CURRENT MOBILITY STATUS** _____

8. Describe modification(s) being requested (use separate sheet of paper if needed):

Modification Requested	Justification	Approved	Denied

9. Projected cost of modification (Include 2 estimates containing delivery and installation costs, if applicable):

Contractor/Provider Name	License #	Provider ID	Cost
			$
			$

SECTION B. TO BE COMPLETED BY AHCCCS

Comments: _____

Approved _____ Signature _____ Date _____
(Name and Title)

Denied _____ Signature _____ Date _____
(AHCCCS Medical Director or physician designee for denials
or qualified professional for approval)

Revised 3/2006, 4/2004

EXHIBIT 1240-5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR
COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(ALTCS MEMBERS 21 YEARS OF AGE AND OLDER)

EXHIBIT 1240-5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY
FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(ALTCS MEMBERS 21 YEARS OF AGE AND OLDER)

SUBMITTED BY:

Provider Name: _____

Provider AHCCCS ID Number: _____ Telephone: _____

MEMBER INFORMATION

Member's Name: _____ Date of Birth: _____
Last First Initial

Member's AHCCCS ID Number: _____ Enrollment: _____
(ALTCS Contractor)

Member's Address: _____

_____

ASSESSMENT FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

Assessment performed by: _____ _____

AHCCCS Provider ID: _____ Telephone: _____

Date of Assessment: _____

Assessment Findings: (If necessary, add attachments to provide the most complete information)

1. Member's Diagnosis: _____

2. Indicate which of the following criteria have been met to determine that oral supplemental nutritional feedings are medically necessary. Check all that apply:

a. The member was at or below the 10th percentile on a nationally recognized height/weight or BMI chart for their age and gender for 3 months or more. IBW = _____	
b. The member has already demonstrated a medically significant decline in weight within the past 3 months (prior to the assessment). Approximate weight loss = _____	
c. The member is able to consume/eat no more than 25% of his/her nutritional requirements from normal food sources. Approximate % member is eating = _____	
d. Absorption problems are evidenced by emesis, diarrhea, dehydration, electrolyte imbalance, significant weight loss, etc. and intolerance/allergy to current food products has been ruled out.	
e. The member requires oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. Pre and/or post-hospitalization. (No authorization required for the first 30 days.)	

3. Past nutritional counseling efforts and alternative nutritional feedings that were tried (include by whom and the length of time that counseling was conducted and/or the alternative feedings that were used.)

ORAL SUPPLEMENTAL NUTRITIONAL FEEDING RECOMMENDATIONS

Type of Nutritional Feeding	Source of Nutrition
Weaning from Tube Feeding	
Oral Feeding - Sole Source (Authorization from the member's program contractor is required)	
Oral Feeding - Supplemental (Authorization from the member's program contractor is required)	
Emergency Supplemental Nutrition (No authorization is required for first 30 days)	

Additional Comments:

Nutritional Assessment Provider Date

Member's PCP/Attending Physician Date

EXHIBIT 1240-6

AHCCCS/ALTCS
HCB SERVICES, SERVICE CODES AND APPLICABLE UNITS OF SERVICE

EXHIBIT 1240-6

AHCCCS/ALTCS
HCB SERVICES, SERVICE CODES AND APPLICABLE UNITS OF SERVICE

HCB SERVICE TYPE	CODE	UNIT INCREMENTS
Adult Day Health Care	S5100 S5101 S5102	15 Minutes (up to 11 units) Half Day (12 – 23 units) Per Diem (24+ units)
Attendant Care	S5125	15 Minutes
Companion Care	S5135 S5136	15 Minutes Per Diem
Emergency Alert System	S5160/RR S5161/RR	1 Unit per Service Installation 1 Unit per Service Maintenance
Habilitation **Day Treatment & Training** **Supported Employment**	 T2021 T2020 T2019 T2018	 15 Minutes (up to 20 units) Per Diem (21+ units) 15 Minutes (up to 23 units) Per Diem (24+ units)
Home Delivered Meals	S5170	1 Unit per Meal
Home Health Services/Home Health Aide	T1021	1 Unit per Visit
***Home Health Services/ RN Intermittent**	S9123	1 Unit per Hour
***Home Health Services/ RN Continuous**	S9123/TG	1 Unit per Hour
***Home Health Services/ LPN Intermittent**	S9124	1 Unit per Hour
***Home Health Services/ LPNContinuous**	S9124/TG	1 Unit per Hour
Homemaker	S5130 S5131	15 minutes Per Diem (Pest Control)
Home Modification	S5165	1 Unit per Home Modification Project
Personal Care	T1019	15 Minutes
Respite - **Short Term In-Home** **Continuous In-Home** **Group Respite**	 S5150 S5151 S5150/HQ	 15 Minutes (48 units and under) Per Diem (49 units and over) 15 Minutes

***See also Exhibit 1240-2**

1250 SERVICES PROVIDED ON AN INPATIENT AND OUTPATIENT BASIS

- **BEHAVIORAL HEALTH SERVICES AND SETTINGS**

Description. AHCCCS covers behavioral health services within certain limitations for ALTCS members. ALTCS members may receive medically necessary behavioral health services (mental health and/or substance abuse services) through an ALTCS Contractor.

Amount, Duration and Scope. Behavioral health services may be provided to members residing in their own home, in an institutional setting specified in Policy 1210, or a HCB approved alternative residential setting specified in Policy 1230 of this Chapter.

Refer to the section on behavioral health services included in Chapter 300, Policy 310, for a listing of covered services, Appendix G of this Manual for a complete description of the services and Chapter 1600 for the case management related behavioral health standard.

- **HOSPICE SERVICES AND SETTINGS**

Description. AHCCCS covers hospice services provided to ALTCS members who meet medical criteria/requirements for hospice services. Hospice services provide palliative and support care for terminally ill members and their family or caregivers in order to meet the physical, emotional, spiritual and social stresses which are experienced during the final stages of illness and during dying and bereavement. These services may be provided in the member's own home, a home and community based (HCB) approved alternative residential setting as specified in Policy 1230 of this Chapter, or the following inpatient settings:

1. Participating hospital

2. Participating nursing care institution, and

3. Free standing hospice.

Providers of hospice care must be licensed and Medicare certified by the Arizona Department of Health Services (ADHS). Refer to Chapter 100 of this manual for rules governing licensure for these facilities.

Amount, Duration and Scope. Hospice services are available only for ALTCS members who have been certified by a physician as being terminally ill and who elect to receive hospice care. If the member is receiving hospice services under Medicaid Title XIX, the services must be ordered by the member's primary care provider (PCP) and authorized by the case manager though the member's service plan. If the member is receiving hospice services under Medicare, the services do not require case manager authorization; however, the case manager remains responsible for monitoring the member's care to ensure the receipt of needed services.

Hospice services may be provided on an inpatient basis when the member's condition is such that care can no longer be rendered in the member's own home or an approved HCB alternative residential setting. Hospice home care services may be provided as routine home care or, when medically necessary, on a continuous home care basis.

Regardless of whether the member is Medicare-primary, or ALTCS-only, the case manager, the member's PCP and hospice staff are responsible for making a coordinated determination regarding the appropriate level of care for the member. If a dispute arises regarding the level of care that is medically necessary for the member, the final determination must be made by the member's PCP.

Medicaid services provided to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits (i.e., home health aide, personal care and homemaker services) will not be covered. Attendant care is not considered a duplicative service.

If the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor may report such cases to the ADHS as the hospice licensing agency in Arizona.

State licensure standards for hospice care require providers to include skilled nursing, respite and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services and inpatient services available as necessary to meet the member's needs. The following components are included in hospice service reimbursement when provided in approved settings:

1. Bereavement services provided by the hospice which include social and emotional support offered to the member's family both before and up to twelve months following the death of that member. (There is no additional cost to ALTCS for bereavement services provided to the family after the death of the member.)

2. Continuous home care (as specified in the definition of hospice services included in Chapter 100 of this Manual) which may be provided only during a period of crisis

3. Dietary services which include a nutritional evaluation and dietary counseling when necessary

4. Home health aide services

5. Homemaker services

6. Nursing services provided by or under the supervision of a registered nurse

7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology or a related field and who is appropriately licensed or certified

8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting indicated above.

9. Routine home care, as specified in the definition of hospice services included in Chapter 100 of this Manual

10. Social services provided by a qualified social worker

11. Therapies which include physical, occupational, respiratory, speech, music and recreational therapy

12. Twenty-four hour on-call service to provide reassurance, information and referral of members and their family or caretaker

13. Volunteer services provided by individuals who are specially trained in hospice care and who are supervised by a designated hospice employee. Pursuant to Title 42 of the Code of Federal Regulations, Section 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such service(s), and

14. Medical supplies, appliances and equipment, including pharmaceuticals, which are used in relationship to the palliation or management of the member's terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.

The unit of service is per diem based. Services are provided as routine home care, continuous home care, inpatient respite care or general inpatient care.

- **MEDICAL/ACUTE CARE SERVICES**

Description. Medical/acute care services are provided as specified in Chapter 300, Policy 310. Medical/acute care services provided to ALTCS members are the same as those provided to members enrolled in the acute care program, with the exception of therapies described in this Chapter.

Amount, Duration and Scope. These services require orders from the member's primary care provider or attending physician, and in some cases, authorization from the member's case manager. Refer to Exhibit 1240-3 in this Chapter for information regarding authorization sources for acute/medical care services and home and community based services (HCBS).

Medical/acute care services may be provided to ALTCS members residing in their own home, institutional setting or any ALTCS approved alternative HCB residential setting, and in conjunction with any HCBS.

- **RESPITE CARE**

Description. AHCCCS covers respite care (short-term care or continuous) for ALTCS members residing in their own home. Services are provided as a non-routine interval of rest and/or relief to a family member or other unpaid persons caring for the ALTCS member, and to improve the emotional and mental well-being of the member.

Amount, Duration and Scope. The services may be provided by a respite provider coming to the member's residence, as well as admitting the member to a licensed institutional facility or an approved home and community based (HCB) alternative residential setting for the respite period.

Short-term respite is defined as 12 hours or less, either in the member's residence or in another facility. The unit of service for short-term respite is 15 minutes. Continuous respite is available to members in need of temporary separation from their family or living environment for time periods of 13 hours or more; the unit of service is per diem. The combined total of short-term and/or continuous respite care cannot exceed 30 days or 720 hours per contract year (October 1 through September 30). The 720 hours is inclusive of behavioral health respite care.

Respite care may only be delivered as specified and authorized by the member's case manager in the member's service plan. If a family member or significant other routinely needs a block of time for relief, attendant care may be considered as an alternative to respite care. Respite services include, but are not limited to:

1. Supervision of the member for the period of time authorized by the case manager

2. Provision of services during the respite period which are within the respite provider's scope of practice, are authorized by the member's case manager and included in the member's service plan, and

3. Providing activities and services to meet the social, emotional, and physical needs of the member during the respite period.

If respite care is provided by one of the facilities listed below, that facility must be licensed by the Arizona Department of Health Services and Medicare certified when applicable.

1. Nursing care institutions

2. Adult day health care providers

3. Approved HCB alternative residential facilities included in Policy 1230 of this Chapter, and

4. Home health agencies (HHA).

Individuals who provide respite care must meet hold a current certification in cardiopulmonary resuscitation and first aid, have appropriate skills and training to meet the needs of each member assigned to them and submit three letters of reference. All references, skills and training must be verified and documented in the employee's personnel file when working for an agency.

If respite care is provided in an institutional setting or a HCB approved alternative residential setting, other ALTCS services may be provided, as allowed in the specific setting and if included in the member's individualized care plan. Examples are as follows:

1. If the member resides in his/her own home and is authorized to receive home health skilled nursing services but is receiving respite care from a nursing facility (NF), the facility may provide nursing services but the services will be included in their per diem.

2. If the member also requires home health therapy services, the NF may provide the services but because they are not part of the NF per diem, the services should be billed/reported in addition to the per diem day. Refer to Policy 1210 of this Chapter for additional information regarding institutional services and Policy 1240 of this Chapter for information related to HCBS.

If respite care is provided in the member's own home, all HCB services included in the member's service plan may be provided in conjunction with respite care. Examples are as follows:

1. If the member is receiving personal care services, he/she may continue to receive this service in conjunction with the respite care. However, if the service is included in the scope of practice of the respite care provider, it is included as a part of the unit rate for respite care and is not billed separately.

2. If the member requires home health skilled nursing services, the services may be provided in conjunction with respite care, but are billed/reported separately by the HHA.

When respite care is determined necessary for ventilator dependent members in their own home, or a HCB approved alternative residential setting, it must be provided at the member's level of medical need. Respite care may be provided by the following:

1. Private duty skilled nursing services, if available and determined to be medically necessary

2. If skilled nursing personnel are unavailable to provide respite care, services may be provided by a respiratory therapist when both of the following conditions are met:

   a. The member's primary care provider must approve/order the care by the respiratory therapist, and

   b. The member's care requirements must fall within the scope of practice for the licensed respiratory therapist as defined in A.R.S. §32-3501 and orientation to the care needs unique to the member must be provided by the usual caregiver or the member.

- **THERAPIES**

Description. AHCCCS covers occupational, physical and speech therapy services, as well as audiology services, that are ordered by a primary care provider (PCP), approved by the AHCCCS Division of Fee for Service Management or the managed care Contractor, and provided by or under the direct supervision of a licensed therapist as noted and applicable in this section.

Members residing in their own home or a HCB approved alternative residential setting may receive physical, occupational and speech therapies through a licensed Medicare-certified home health agency (HHA) or by a qualified licensed physical, occupational or speech therapist in independent practice, as applicable.

Services require a primary care provider (PCP) or attending physician's order and must be included in the member's individualized care plan. The care plan must be reviewed at least every 62 days (bimonthly) by the member's PCP or attending physician when services are received in home or in an approved alternative setting.

Amount, Duration and Scope. Therapy services must be prescribed by the member's primary care provider (PCP) or attending physician as a medically necessary treatment to develop, improve or restore functions/skills which have not been attained, are underdeveloped or have been impaired, reduced or permanently lost due to illness or injury. Therapy services related to activities for the general good and welfare of members, activities to provide diversion or general motivation do not constitute therapy services for Medicaid purposes and are not covered under ALTCS.

The therapy must relate directly and specifically to an active written treatment regimen or care plan established by the member's physician for reasonable and necessary treatment of a member's illness or injury, habilitation or rehabilitation. If necessary, the physician should consult with a qualified therapist.

For purposes of this Policy, reasonable and necessary means:

1. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the member's condition.

2. Based on the assessment made by the PCP/attendingphysician of the member's restoration potential, there must be an expectation that the condition will improve significantly in reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required for a specific injury or illness, and

3. The amount, frequency and duration of the services must be reasonable.

Developmental/Restorative Therapy

A therapy service must be reasonable and necessary to the functional development, and/or treatment of the member's illness or injury. If the member's expected potential for improving or restoring functional level is insignificant in relationship to the type and number of therapy services required to achieve such potential the therapy would not be covered for other than a maintenance program as described below. If at any point in the development of skills, or the treatment of an illness or injury, it is determined that the therapy expectations will not materialize, the services will no longer be considered reasonable and necessary.

Maintenance Program

If the developmental or restorative potential is evaluated as insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified therapist may be required to assess and establish the maintenance program to achieve the treatment goals of the ordering PCP or attending physician. After the member's condition has been assessed, and the member's caregiver has been instructed/trained in the established maintenance program components, the services of the qualified therapist are no longer covered except for reassessments and treatment plan revisions. Refer to Chapter 300 for additional information regarding therapy services.

Physical Therapy

Description. AHCCCS covers physical therapy (PT) services for ALTCS members. Services provide treatment to develop, restore, maintain or improve muscle tone and joint mobility and to develop or improve the physical/functional capabilities of members.

Amount, Duration and Scope. Physical therapy services must be rendered by a qualified physical therapist licensed by the Arizona Physical Therapy Board of Examiners, or a physical therapy assistant (under the supervision of the PT, according to 4 A.A.C. 24, Article 3) certified by the Arizona Physical Therapy Board of Examiners. Therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal regulations. Refer to Chapter 100 of this Manual for a listing of licensure rule citations pertaining to physical therapists and PT assistants.

One unit of service (15 minute increments) is equal to an authorized treatment service and includes, but is not limited to:

1. Administering and interpreting tests and measurements performed within the scope of the practice of PT as an aid to the member's treatment

2. The administration, evaluation and modification of treatment methodologies and instruction, and

3. The provision of instruction or education, consultation and other advisory services.

Occupational Therapy

Description. AHCCCS covers occupational therapy for ALTCS members to achieve their highest level of functioning, maximize independence, prevent disability and maintain health. Services may be provided to members who are functionally limited due to physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, socioeconomic and cultural differences or the aging process. The services include activities such as evaluation, treatment and consultation.

Amount, Duration and Scope. Occupational therapy (OT) services must be provided by a qualified occupational therapist licensed by the Arizona Board of Occupational Therapy Examiners or certified OT assistant (under the supervision of the OT , according to 4 A.A.C. 43, Article 4) licensed by the Arizona Board of Occupational Therapy Examiners. Therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal regulations.

One unit of service (15 minute increments) is equal to an authorized treatment service and includes, but is not limited to:

1. Evaluation of, and training in, activities of daily living, social skills, work and related activities

2. Development or enhancement of functional achievement, pre-vocational skills and work capabilities through the use of therapeutic, kinetic, functional, manual and creative activities or exercises

3. Assessment and adaptation of the member's living and work environments for individuals with disabilities, handicaps and those at risk for dysfunction, and

4. Other duties or tasks included in the therapist's care plan for the member that are necessary to assist the member in gaining or maintaining his/her highest level of self sufficiency.

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Speech Therapy

Description. AHCCCS covers speech therapy (ST) services for ALTCS members who need to develop, increase or improve communication effectiveness and/or their oral functioning, including swallowing. ST services include evaluation, program recommendation for treatment and/or training in receptive and expressive language, voice, articulation, fluency and aural habilitation and rehabilitation, and medical issues dealing with swallowing.

Amount, Duration and Scope. ST must be provided by a qualified certified speech-language pathologist licensed by the Arizona Department of Health Services (ADHS) or a speech-language pathologist who ahs a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified speech-language pathologist and complete the fellowship within 2 years or the registration is terminated. Therapists who provide services to AHCCCS members outside the State of Arizona must meet the applicable State and/or Federal regulations.

One unit of service is equal to an authorized treatment service and is limited to one unit per day. Covered speech-language pathology services consist of evaluation and therapy.

Services include, but are not limited to:

1. Services concerned with diagnosis or evaluation which includes language assessment tests to ascertain the type, casual factor(s) and severity of the speech language disorder, and

2. Therapeutic services for common medical conditions or disorders with resulting communication deficits that necessitate active developmental or restorative therapy.

Services include, but are not limited to:

1. Conducting a current assessment and/or a review of previously administered speech/language assessments in order to develop an individual speech/language program

2. Development and implementation of a speech/language program to meet member needs and included in therapist's care plan for the member

3. Evaluation of the effectiveness of the program on a regular basis, modifying the program required, and notifying the case manager of any changes, and

4. Training appropriate individuals involved with the member to perform necessary therapeutic activities to implement the speech-language program, and

5. Swallowing evaluation and training.

Some members require services involving non-diagnostic, non-therapeutic, routine, repetitive and reinforced procedures or services for their general good and welfare, such as practicing word drills. These services are not covered since they do not require a qualified speech-language pathologist.

Audiology

Description. Audiology is an AHCCCS covered service, within certain limitations, to evaluate hearing loss and rehabilitate members with hearing loss through other than medical/surgical means.

Amount, Duration and Scope. AHCCCS covers medically necessary audiology services to evaluate hearing loss for ALTCS members on both an inpatient and outpatient basis.

Beginning June 28, 2004, audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the Federal requirements specified under 42 CFR 440.110. Out-of-state audiologists must meet the Federal requirements.

The Federal requirements mandate that the audiologist must have a Master's or Doctoral degree in audiology and meet one of the following conditions:

1. Have a certificate of clinical competence in audiology granted by the American Speech-Language Association (ASHA), or

2. Have successfully completed a minimum of 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised experience under the supervision of a qualified Master's or Doctoral-level audiologist), performed not less than nine months of supervised full-time audiology services after obtaining a Master's or Doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

Hearing aids provided as a part of audiology services are covered only for members under the age of 21 who are receiving EPSDT services or are enrolled in KidsCare. Hearing aids can be dispensed only by a dispensing audiologist or an individual with a valid hearing aid dispensing license issued by ADHS.

Refer to Chapter 400 for additional information on services provided to persons under the age of 21 and the EPSDT program.

- **RESPIRATORY THERAPY**

Description. AHCCCS/ALTCS covers respiratory care services prescribed by a primary care provider (PCP) or attending physician to restore, maintain or improve respiratory functioning. Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures; observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care; diagnostic testing and treatment; and implementing appropriate reporting and referral protocols.

Amount, Duration and Scope. Services must be provided by a qualified respiratory practitioner under A.R.S. §32-3501 (respiratory therapist or respiratory therapy technician) licensed by the Arizona Board of Respiratory Care Examiners.

In addition, a licensed respiratory practitioner participates with the case manager to develop the member's service plan, develop and teach therapy objectives and/or techniques to be implemented by family members or the staff of the institution or HCB alternative residential setting where the member resides, and perform other duties and tasks which are included in the therapist's care plan for the member and are designed to restore, maintain or improve respiratory function.

Services may be provided to members in an Arizona Department of Health Services licensed institutional setting as specified in Policy 1210 of this Chapter. ALTCS members residing in their own home or a HCB approved alternative residential setting may also receive respiratory care provided through a licensed, Medicare certified home health agency or by a qualified licensed respiratory therapist in private practice.

Services require a physician's order and must be included in the member's individualized care plan. The care plan must be reviewed at least every 62 days (bimonthly) by the member's primary care provider or attending physician.

One unit of service is equal to one authorized treatment, and limited to one procedure per day.

Note: If skilled nursing personnel are unavailable to provide ventilator dependent care services in the member's own home or HCB approved alternative residential setting, services may be provided by a licensed respiratory practitioner when both of the following conditions are met:

1. The member's PCP must approve/order the care by the respiratory therapist, and

2. The member's care requirements must fall within the scope of practice for the licensed respiratory therapist as defined in A.R.S. §32-3501 and orientation to the care needs unique to the member must be provided by the usual caregiver and/or the member.

Refer also to Chapter 300 for therapy descriptions.

1260 RESERVED

1270 RESERVED