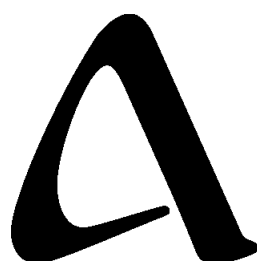


Chapter 21

ALTCS Services



AHCCCS

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COVERED SERVICES

NOTE: The covered services, limitations, and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual and AHCCCS Administrative Rules A.A.C. R9-28-201 et seq. and R9-22-201 et seq. Please direct questions to the AHCCCS Office of Medical Management at (602) 417-4627. The AHCCCS Medical Policy Manual is available on the AHCCCS Web site at www.azahcccs.gov.

The Arizona Long Term Care System (ALTCS) provides care for the developmentally disabled and the elderly and physically disabled. ALTCS provides institutional care and home and community based services to recipients who are at risk of institutionalization. Covered services include:

- Medical services
- Institutional services, including:
 - ✓ Nursing facilities
 - ✓ Inpatient psychiatric facilities for individuals under age 21 (RTCs)
 - ✓ Intermediate care facilities for mentally retarded (not covered for fee-for-service recipients)
- Home and community based services (HCBS) provided in lieu of institutionalization
- Hospice services
- Speech, physical, and occupational therapies when provided in nursing facilities and alternate residential facilities and as part of HCBS
- Behavioral health services
- Durable medical equipment and medical supplies
- Private duty nursing services

COVERAGE LIMITATIONS

- Private rooms in nursing facilities require physician orders and must be medically necessary.
- Services for ventilator dependent recipients must be provided in the individual's residence or a nursing facility.
- Respite care is limited to 600 hours per benefit year.
- Therapeutic leave days are limited to nine days per contract year.



- Bed hold days for recipients admitted to a hospital for a short stay are limited to 12 days per contract year.
- Habilitation services are a separate service category for individuals with developmental disabilities.

ELIGIBILITY

Application for ALTCS may be made at any of the ALTCS offices located throughout Arizona (See Exhibit 21-2). An individual may submit his or her own application or may have a family member or other representative make the application.

Applicants must meet financial and medical eligibility requirements. When it appears that an applicant is financially eligible for ALTCS, medical eligibility is determined by a Preadmission Screening (PAS). The PAS measures functional and medical disability to determine if the applicant is at risk of institutional placement.

Once determined eligible, recipients who are elderly or have physical disabilities are enrolled with a program contractor in their county of residence. American Indians who maintain a residence on the reservation are enrolled with a tribal contractor and receive services on a fee-for-service basis. All persons with developmental disabilities are enrolled with the Department of Economic Security, Division of Developmental Disabilities (DES/DD).

CASE MANAGEMENT

All ALTCS recipients are assigned a case manager who is responsible for identifying, planning, obtaining, and monitoring appropriate and cost-effective medical and medically related services.

The AHCCCS Administration maintains intergovernmental agreements (IGA) with seven tribal governments for the delivery of ALTCS case management services to tribal members with ties to their respective reservations. The seven tribal governments are the Pascua Yaqui Tribe, Gila River Indian Community, Tohono O'odham Nation, San Carlos Apache Tribe, White Mountain Apache Tribe, Navajo Nation, and the Hopi Tribe.



Members of other tribes without an IGA are enrolled with the Native American Community Health Center (NACHC). NACHC and the tribal governments employ case managers who are responsible for coordinating ALTCS services to recipients. The tribes and NACHC receive a monthly capitation based on the number of tribal ALTCS members enrolled. All other services are provided and reimbursed on a fee for services basis.

Case manager authorization of ALTCS services is required unless:

- The recipient has Medicare or other insurance coverage *and* the services are covered by Medicare or the other insurance, or
- Services were provided during a period when the recipient was retroactively eligible.

Among the ALTCS services that require authorization are:

- Medically necessary non-emergency transportation
- Homemaker services, attendant care, and personal care
- Respite (in home and nursing facility)
- Home health nurse and home health aide
- Therapy (occupational, speech, respiratory, and physical)
- DME, all orthotic and prosthetic devices, and medical supplies (orthotics are not covered for recipients age 21 years and older)
- Adult day health and home delivered meals
- Nursing facility services, including bed hold and therapeutic leave days
- Acute Care services

Acute care services such as in-patient hospitalizations for non-Medicare covered recipients and outpatient surgery must be authorized by the AHCCCS Prior Authorization Unit. Case managers generally are not involved with acute care service authorization.

To arrange services, the case manager first contacts the appropriate provider. Once arrangements are confirmed, the case manager enters the authorized services in the Case Management Service Plan in the AHCCCS system. An authorization letter is automatically sent to the provider (except nursing facilities) verifying the services authorized.



The information entered on the claim form must match what has been authorized and listed on the confirmation letter. The AHCCCS claims system matches the claim information against established authorizations and identifies the appropriate case manager authorization for the services that require authorization. If there are any discrepancies between the service billed and the authorized service, the system will not find the appropriate authorization, and the claim will be denied. (See Exhibit 21-1 for a sample authorization letter.)

NURSING FACILITY SERVICES

Nursing facilities provide care for the chronically ill and for those recuperating from illness who need nursing care but not hospitalization. Many facilities offer several levels of care and various specialized services such as therapies. A limited number serve patients with extensive rehabilitation needs, problems due to wandering behavior, or serious respiratory problems. (See Chapter 22, Nursing Facility Services, for a detailed description of nursing facility services)

HOME AND COMMUNITY BASED SERVICES (HCBS)

Home and community based services (HCBS) are services for ALTCS recipients residing in their homes who would otherwise require supervision and assistance through nursing facility services.

Covered HCBS services include:

- Assisted living facility
 - ✓ ALTCS covers services, except room and board, for EPD recipients who are physically or functionally unable to live independently in the community but can have their needs met safely while residing in an assisted living facility.
 - Assisted living homes provide room, board, personal care and supervision for up to 10 adults.
 - Adult foster care homes provide room, board, personal care, and supervision for one to four adults in a family environment
 - Assisted living centers (units only) provide room, board, personal care, and supervision for more than 10 adults.
 - Alzheimer's demonstration assisted living facilities provide room, board, and supervision to adults who require dementia care.



Covered HCBS services include (Cont.):

- Adult day health
 - ✓ Adult day health services provide supervision, recreation, socialization, personal care, personal living skills training, congregate meals, health monitoring and other health-related services.
- Attendant care
 - ✓ Attendant care services provide assistance with homemaking, personal care, general supervision, and companionship for a recipient in his/her own home as an alternative for those who may otherwise have to go to a nursing facility.
- Home delivered meals
 - ✓ Home delivered meal services provide for one meal per day containing at least 1/3 of the Recommended Dietary Allowance to be delivered to a recipient's residence (Covered only for EPD recipients).
- Homemaker services
 - ✓ Homemaker services provide assistance to a recipient in the performance of activities related to household maintenance
- Home health services
 - ✓ Home health services provide intermittent in-home care for recipients such as nursing services, home health aides, medical supplies, equipment and appliances, and therapies (See Chapter 20, Home Health Care Services).
- Hospice services
 - ✓ Hospice services provide supportive care for terminally ill recipients and their family or caregivers in the home or in an institution (See Chapter 23, Hospice Services).
- Personal care services
 - ✓ Personal care services provide assistance to recipients who need help doing essential activities of daily living (i.e., eating, bathing, dressing)
- Respite services
 - ✓ Respite services provide short term or intermittent care and supervision in order to provide an interval of rest or relief for family members
 - ✓ Respite services include up to 600 hours per benefit year.
 - ✓ Short-term in-home respite service cannot exceed 12 hours on a specific date



THERAPY SERVICES

- AHCCCS covers physical, occupational, speech and respiratory therapy services that are:
 - ✓ Ordered by a physician, and
 - ✓ Provided by or under the direct supervision of a licensed therapist.

- Occupational Therapists must be licensed by the Arizona Board of Occupational Therapy Examiners, or governing Board of the State where the therapist practices or a certified OT assistant (under the supervision of the occupational therapist) licensed by the Arizona Board of Occupational Therapy Examiners.
 - ✓ AHCCCS covers medically necessary OT services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.
 - ✓ Outpatient speech and occupational therapy services are covered only for EPSDT and ALTCS recipients.

- Therapy services may include, but are not limited to:
 - ✓ Cognitive training
 - ✓ Exercise modalities
 - ✓ Hand dexterity
 - ✓ Hydrotherapy
 - ✓ Joint protection
 - ✓ Manual exercise
 - ✓ Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
 - ✓ Perceptual motor testing and training
 - ✓ Reality orientation
 - ✓ Restoration of activities of daily living
 - ✓ Sensory reeducation, and
 - ✓ Work simplification and/or energy conservation.

- Physical Therapists must be licensed by the Arizona Board of Physical Therapy or the governing Board of the State where the therapist practices or a Physical Therapy Assistant (under the supervision of the PT) certified by the Arizona Physical Therapy Board of Examiners.
 - ✓ Physical therapy (PT) is an AHCCCS covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function.



- ✓ AHCCCS covers medically necessary PT services for members in an inpatient or outpatient setting, when services are ordered by the member's PCP/Attending physician as follows:
 - 1. Inpatient
 - a. Inpatient PT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility)
 - 2. Outpatient
 - a. Outpatient PT services are covered for EPSDT and KidsCare members when medically necessary.
- ☑ In accordance with AHCCCS Administrative Rules A.A. C. R9-22-215 and R9-28-202 outpatient PT services are covered for adult members, 21 years of age and older (ACUTE and ALTCS) as follows:
 - ✓ Service limits will be applied to physical therapy CPT codes 97001-97546
- ✓ A physical therapy visit is defined as:
 - ☑ An occurrence of CPT codes 97001-97546
 - ☑ Billed on form types 1500 and UB-04 outpatient
 - ☑ Any provider type except:
 - 13- Occupational therapist
 - 22- Nursing home
 - ☑ Any place of service excluding:
 - 31- Nursing home
 - 32- Nursing facility
 - 33- Custodial facility
- ☑ Member is Medicaid only and is not Medicare eligible. (Also known as non dual)
 - ✓ Contractor is responsible for the visit up to 15 PT visits per contract year.
- ☑ Member is Dual Eligible (Also known as Medicare Primary, non QMB dual)
 - ✓ Contractor is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to 15 PT visits.
 - ✓ In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will pay the Medicare cost sharing up to the 15 visit limit per contract year.



- As part of their Medicare benefit, members may opt to receive service up to Medicare maximum dollar amount; **however** the Medicare cost sharing for any visits beyond the 15 visit limit allowed by AHCCCS are the members' responsibility.
- ✓ In the event that the member exhausts the Medicare dollar maximum amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.
- Member is QMB Dual
- ✓ Contractor is responsible for Medicare cost sharing up to Medicare maximum dollar amount.
 - In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.
 - In the event that member exhausts the Medicare maximum dollar amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.
- Definitions:
 - ✓ **Visit** - a visit equals PT services received in one day per provider. The 15 visit limit applies regardless that the member has the same contractor or changes contractors during the contract year.
 - ✓ **Setting** - Any out patient place of service. (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).
 - ✓ **Dual Eligible (Non-QMB Dual)** - An individual who is Medicare and Medicaid eligible with income above 100%FPL. The individual does not qualify for QMB.
 - ✓ **QMB Dual** -An individual who is Medicare and Medicaid eligible with income not exceeding 100%FPL.
- ✓ Physical therapy prescribed only as a maintenance regimen is excluded



- ✓ Authorized treatment services include, but are not limited to:
 - ☒ The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member's treatment
 - ☒ The administration, evaluation and modification of treatment methodologies and instruction, and
 - ☒ The provision of instruction or education, consultation and other advisory services.

- ☒ A qualified Speech-Language Pathologist (SLP) must be licensed by the Arizona Department of Health Services (ADHS) or a Speech-Language Pathologist who has 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. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed.

- ☒ A qualified Speech-Language Pathology Assistant (SLPA) must be licensed by the Arizona Department of Health Services (ADHS). The SLPA must be identified as the servicing provider and bill for services under his or her individual NPI number. (A group ID number can be utilized to direct payment) SPLA's may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.

- ✓ AHCCCS covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP or attending physician for FFS members. Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

- ✓ Speech therapy by qualified professionals may include the list below:
 - ☒ Articulation training
 - ☒ Auditory training
 - ☒ Cognitive training
 - ☒ Esophageal speech training
 - ☒ Fluency training
 - ☒ Language treatment
 - ☒ Lip reading
 - ☒ Non-oral language training
 - ☒ Oral-motor development, and
 - ☒ Swallowing training.

- ✓ Respiratory therapists must be billed with the following code:
 - S5180 Home health respiratory therapy, initial evaluation



- ✓ Respiratory therapists may not use CPT codes 94010 - 94799.
- ✓ Physicians and hospitals may use CPT codes 94010 - 94799.
- ✓ No outpatient rehabilitation services are covered for ESP recipients.

Prior authorization requirements:

- The following written documentation must be received by the AHCCCS/DFSM/PA Unit prior to the issuance of a PA number:
 - ✓ Nature, date, extent of injury/illness and initial therapy evaluation
 - ✓ Treatment plan, including specific services/modalities of each therapy, and
 - ✓ Expected duration and outcome of each therapy provided.
- Upon concurrent review and/or receipt of above documentation, which substantiates AHCCCS rehabilitation requirements, authorization will be given.
- Progress notes may be requested by the AHCCCS/DFSM/PA Unit every 10 days, as evidence of member progress for continued authorization (when there is no concurrent review).

BILLING FOR SERVICES

HCBS providers must bill for services on a CMS 1500 claim form. Claims for services will be compared with the case manager's authorization for the services. The match criteria includes:

- Provider ID
- Recipient ID
- Date(s) of Service
- Procedure Code
- Units of Service

If a nursing facility, HCBS, or therapy claim does not match the information on the Case Manager Service Plan, the claim will be denied.

ALTCS recipients who receive long term care services may be responsible for paying a portion of the cost of their care. This payment liability is called share of cost (SOC).



The SOC calculation is a final step in the completion of the ALTCS application. SOC is calculated by subtracting certain expenses and deductions from the recipient's gross income. Calculations differ for recipients residing in nursing facilities and those receiving HCBS.

HCBS recipients have a personal needs allowance deducted from their income which usually is equal to the maximum income allowed for eligibility. Therefore, these recipients rarely have a SOC. Occasionally, an HCBS recipient will have income that is not counted toward eligibility in addition to other types of income or may receive a reduced personal needs allowance. In this case, the recipient may have a SOC.

Recipients in a nursing facility have a personal needs deduction of 15 per cent of the SSI federal benefit rate (which changes each January) and frequently have a SOC.

Deductions for spousal, family, or home maintenance; medical insurance premiums; and non-covered medical expenses may reduce the amount of a recipient's SOC. Because a recipient's income and expenses may fluctuate from month to month, SOC is calculated monthly.

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SAMPLE ALTCS AUTHORIZATION LETTER



ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

JANICE BREWER
Governor

THOMAS BETLACH
Director

October 15, 2011

654321
PROVIDER NAME
PROVIDER ADDRESS
CITY, STATE ZIP

CORRESPONDENCE REQUEST NUMBER: 314748 LTC PA LTR (PROVIDER APPROVAL)
LONG TERM CARE KEY INFORMATION: A12345678199

TO PROVIDER NAME:

THIS IS YOUR AUTHORIZATION CONFIRMATION FOR THE SERVICE(S) WHICH REQUIRE AUTHORIZATION FROM THE ARIZONA LONG-TERM CARE SYSTEM (ALTCS) ADMINISTRATION. THESE SERVICES HAVE BEEN APPROVED. RECEIPT OF THIS NOTIFICATION IS NOT A GUARANTEE OF PAYMENT.

PROVIDER ID/NAME : 654321 (PROVIDER NAME)
RECIPIENT ID/NAME : A123456789 (EARP, WYATT DOB: 10/01/66 SEX: M)
RECIPIENT DATE OF BIRTH : 10/01/66
SERVICE CODE : T1019 (PERSONAL CARE SERVICES, PER 15 MINUTES)
DIAGNOSIS CODE : 799.9
SERVICE DATE FROM : 09/22/2011
SERVICE DATE THROUGH : 09/26/2011
UNITS APPROVED : 48
CASE MANAGER ID : 999999
CASE MANAGER NAME : LAST NAME, FIRST NAME
CASE MANAGER PHONE NUMBER : 5209991234

NOTE: THE AUTHORIZATION (PA) NUMBER HAS BEEN ELIMINATED. NO PA NUMBER IS REQUIRED ON THE CLAIM FORM. RECEIPT OF THIS NOTICE NOW SERVES AS PROOF THAT AUTHORIZATION WAS PROVIDED BY THE CASE MANAGER FOR SERVICE(S) TO BE RENDERED.

BILLING QUESTIONS SHOULD BE DIRECTED TO THE AHCCCS CLAIMS CUSTOMER SERVICE UNIT AT (602) 417-7670 OR 1-800-794-6862.

ANY QUESTIONS PERTAINING TO THE SERVICE(S) DELIVERED TO AN ALTCS RECIPIENT SHOULD BE DIRECTED TO THE ACTUAL CASE MANAGER WHO REQUESTED THE SERVICE(S)

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AHCCCS ADMINISTRATION

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Exhibit 21-2

ALTCS OFFICES

CASA GRANDE

500 N. Florence St.
Casa Grande, AZ 85222
(520) 421-1500
FAX: (877) 666-0874

CHINLE

Tseyi Shopping Center
US Hwy 191
P.O. Box 1942
Chinle, AZ 86503
(928) 674-5439
Toll Free: 1-888-800-3804
FAX: (877) 660-1450

COTTONWOOD

One N. Main St.
Cottonwood, AZ 86326
(928) 634-8101
FAX: (877) 666-5208

FLAGSTAFF

2717 N. Fourth St, Ste 130
Flagstaff, AZ 86004
(928) 527-4104
Toll Free: 1-800-540-5042
FAX: (877) 663-5213

GLOBE/MIAMI

Cobre Valley Plaza
2250 Hwy 60, Suite H
Miami, AZ 85539-9700
(928) 425-3165
Toll Free: 1-888-425-3165
FAX: (877) 666-5219

KINGMAN

519 E. Beale St., Suite 150
Kingman, AZ 86401
(928) 753-2828
Toll Free: 1-888-300-8348
FAX: (877) 667-5239

LAKE HAVASU CITY

2160 N. McCulloch Blvd., Suite # 105
Lake Havasu City, AZ 86403
(928) 453-5100
Toll Free: 1-800-654-2076
FAX: (877) 664-5264

PHOENIX

801 E. Jefferson St., MD # 1600
Phoenix, AZ 85034
(602) 417-6600
FAX: (602) 253-6385

PRESCOTT

1519 W. Gurley St., Suite # 11
Prescott, AZ 86305
(928) 778-3968
Toll Free: 1-888-778-5600
FAX: (877) 666-5269

SHOW LOW

580 E. Old Linden Road, Suite 3
Show Low, AZ 85901
(928) 537-1515
Toll # 877-537-1515
FAX: (877) 666-5286

SIERRA VISTA

2981 E. Tacoma (Street address)
1010 N. Finance Center Dr., Suite # 201 (Mailing
address)
Tucson, AZ 85710
(520) 205-8600
FAX: 1-800-824-2656

TUCSON

1010 N. Finance Center Dr., Suite #201
Tucson, AZ 85710
(520) 205-8600
Toll Free: 1-800-824-2656
FAX: (877) 666-5353

VALLEY

801 E. Jefferson St, MD# 800
Phoenix, AZ 85034
(602) 417-6400 or (602) 417-6000
FAX: (602) 253-4871

VALLEY ALTCS

GLENDALE ANNEX

Street Address: 2830 W. Glendale Ave., Suite 34
Mailing Address: 801 E. Jefferson, MD# 800
Phoenix, AZ 85034
(602) 417-6000
FAX: (602) 253-4871

YUMA

3850 W. 16th Street
Suite A
Yuma, AZ 85364
(928) 782-0776
FAX (877) 666-5382

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