REVISION DATES: 11/3/22; 7/26/19; 5/04/2018; 1/23/2018; 10/01/2017; 10/01/2016; 10/01/2015; 12/18/2013

General Information

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 Code A.A.C. R9-28-201 et seq. and R9-22-201 et seq. The AHCCCS Medical Policy Manual is available on the AHCCCS website at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/

OVERVIEW

The Arizona Long Term Care System (ALTCS) provides care and services for eligible individuals who are elderly and/or those with physical or developmental disabilities. ALTCS provides institutional care and home and community based services to members who have been determined to be at risk of institutionalization.

Covered services include the following when considered medically necessary:

1. Medical services
2. Institutional services, including:
    a. Nursing facilities
    b. Inpatient psychiatric facilities for individuals under age 21 (RTCs)
    c. Intermediate care facilities for person with Intellectual Disabilities (not covered for Fee-for-Service members)
3. Home and community based services (HCBS)
4. Hospice services
5. Speech, physical, and occupational therapies
6. Behavioral health services
7. Durable medical equipment and medical supplies
8. Private duty nursing services
9. Limited Dental Services (effective 10/01/2016 service date)
10. Emergency Dental Services (effective 10/01/2017 service date)

COVERAGE LIMITATIONS

Private rooms in nursing facilities require physician orders and must be medically necessary.

Respite care is limited to 600 hours per benefit year.

Attendant Care, when provided by the member's spouse, is limited to no more than 40 hours per week.

Therapeutic leave days are limited to nine days per contract year.

Bed hold days for members admitted to a hospital for a short stay are limited to 12 days per contract year.

Home based services not provided when member is in the hospital.

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, members who are elderly or have physical disabilities (referred to as EP/D members) are enrolled with a program contractor in their county of residence. American Indian EP/D members 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 (referred to as DD members) are enrolled with the Department of Economic Security, Division of Developmental Disabilities (DES/DDD).

CASE MANAGEMENT

All ALTCS members 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 EP/D 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.

EP/D members of other tribes without an IGA are enrolled with Native Health. Native Health and the tribal governments (referred to as Tribal Contractors) employ case managers who are responsible for coordinating ALTCS services to members.

The Tribal Contractors receive a monthly capitation for case management services, based on the number of tribal ALTCS members enrolled. Providers and Tribal Contractors are prohibited from billing for Case Management Services (T1016).

All other services are provided and reimbursed on a fee for service basis.

Case manager authorization of ALTCS services is required unless:

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

ALTCS services that require authorization are:

1. Medically necessary non-emergency transportation (when mileage exceeds 100 miles)
2. Homemaker services, attendant care, and personal care
3. Respite (in home and nursing facility)
4. Home health nurse and home health aide
5. Therapy (occupational, speech, respiratory, and physical)
6. DME, all orthotic and prosthetic devices, and medical supplies
7. Adult day health and home delivered meals
8. Nursing facility services, including bed hold and therapeutic leave days
9. Acute Care services

Acute care services such as in-patient hospitalizations for non-Medicare covered members and outpatient surgery must be authorized by the AHCCCS Care Management Services Unit (CMSU). Tribal case managers 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 provider's 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 members who are chronically ill and/or for those recuperating from illness that 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. (Refer to AMPM Chapter 1200.)

HOME AND COMMUNITY BASED SERVICES (HCBS)

Home and community based services (HCBS) are services for ALTCS members residing in their homes who would otherwise require supervision and assistance through nursing facility services. (Refer to the AMPM Chapter 1200 for detailed description of these services, coverage, requirements and, limitations.)

Covered HCBS services include:

1. Assisted living facility
   ALTCS covers services, except room and board, for EP/D members 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 provide room, board, personal care, and supervision for more than 10 adults.

2. Adult day health services provide supervision, recreation, socialization, personal care, personal living skills training, congregate meals, health monitoring and other health-related services.

3. Attendant care services provide assistance with homemaking, personal care and general supervision for a member in his/her own home as an alternative for those who may otherwise have to go to a nursing facility.

4. 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 member's residence (Covered only for EP/D members).

5. Homemaker services provide assistance to a member in the performance of activities related to household maintenance.

6. Home health services provide intermittent in-home care for members such as nursing services, home health aides, medical supplies, equipment and appliances, and therapies (See Chapter 20, Home Health Care Services).

7. Hospice services provide supportive care for terminally ill members and their family or caregivers in the home or in an institution (See Chapter 23, Hospice Services).

8. Personal care services provide assistance to members who need help doing essential activities of daily living (i.e., eating, bathing, dressing).

9. Respite services provide short term or intermittent care and supervision in order to provide an interval of rest or relief for family members, up to 600 hours per benefit year. Short-term in-home respite service cannot exceed 12 hours on a specific date. When necessary and authorized, more than 12 hours of respite in a 24 hour period can be authorized as continuous respite.

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 Therapy

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 attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Outpatient occupational therapy services are covered for ALTCS members when medically necessary.

Occupational Therapy services may include, but are not limited to:

1. Cognitive training
2. Exercise modalities
3. Hand dexterity
4. Hydrotherapy
5. Joint protection
6. Manual exercise
7. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive
1. device or splint
8. Perceptual motor testing and training
9. Reality orientation
10. Restoration of activities of daily living
11. Sensory reeducation, and
12. Work simplification and/or energy conservation.

Physical Therapy

Physical Therapists must be licensed by the Arizona Board of Physical Therapy or the governing Board of the State where the therapist practices. A Physical Therapy Assistant (under the supervision of the PT according to A.A.C. 24, Article 3) must be certified by the Arizona Physical Therapy Board of Examiners. Out of state physical therapists providing services to AHCCCS members outside the State of Arizona must meet applicable State and/or Federal requirements.

Physical Therapy (PT) is an AHCCCS covered treatment service to restore or improve muscle tone, joint mobility or physical function. Physical therapy prescribed only as a maintenance regimen is excluded.

AHCCCS covers medically necessary PT services for members in an inpatient or outpatient setting, when services are ordered by the member's attending physician.

Inpatient PT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility).

For Outpatient PT services please refer to AMPM 310-X.

Service limits will be applied to physical therapy CPT codes 97001-97546.

A physical therapy visit is defined as:

1. An occurrence of CPT codes 97001-97546
2. Billed on form types 1500 and UB-04 outpatient
3. Any provider type *except:*

13	Occupational Therapist
22	Nursing Home

4. Any place of service excluding:

31	Nursing Home
32	Nursing Facility
33	Custodial Facility

Physical Therapy Definitions:

Visit - a visit equals PT services received in one day per provider. The PT service limit applies regardless whether the member has the same AHCCCS health plan or changes plans during the contract year.

Setting - the location of service i.e. outpatient, inpatient, institutional (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).

Service limits prior to 01/01/2014
In accordance with A.A.C. R9-22-215, outpatient PT services are covered for adult members, 21 years of age and older (ACUTE and ALTCS), as follows:

A. AHCCCS members who are not Medicare eligible are limited to 15 outpatient visits per contract year regardless of whether or not the member changes Contractors. (Contract year is defined as October 1-September 30.)

B. For AHCCCS members who are also Medicare members, refer to AMPM Chapter 300, Exhibit 300-3A regarding Medicare cost sharing and the outpatient physical therapy limit.

Dual Eligible refers to a member with income above 100% FPL who is Medicare and AHCCCS eligible (also known as Medicare Primary, non-QMB dual). The member does not qualify for the Federal QMB program. The health plan is responsible for the Medicare cost sharing amount (Medicare's deductible, copay and coinsurance) up to 15 PT visits.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan 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 member's responsibility.

Should the member exhaust their 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 health plan.

QMB Dual refers to a member with income not exceeding 100% FPL who qualifies for Medicare under the Federal QMB program and is enrolled in Medicaid. The health plan is

responsible for the Medicare cost sharing amount (Medicare deductible and coinsurance) up to the Medicare maximum dollar amount.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.

Should the member exhaust their 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 health plan.

Effective 1/1/2014 service limits for medically necessary outpatient physical therapy for adults (age 21 years and older) are as follows:

A. 15 visits per contract year (October 1-September 30) to restore a particular skill or function the member previously had but lost due to injury or disease and maintain that function once restored; and
B. 15 visits per contract year (October 1-September 30) to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

Refer to AMPM Exhibit 300-3A for more detail regarding Medicaid only members, QMB Dual and Medicare Primary (non-QMB Dual).

Covered physical therapy treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of 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.

Physical therapy prescribed only as a maintenance regimen is excluded.

Speech Therapy

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 the 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 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:

1. Articulation training
2. Auditory training
3. Cognitive training
4. Esophageal speech training
5. Fluency training
6. Language treatment
7. Lip reading
8. Non-oral language training
9. Oral-motor development, and
10. Swallowing training.

Respiratory Therapy

Respiratory therapists must be billed with the 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.

Respiratory Therapy Prior Authorization Requirements

The following written documentation must be received by the AHCCCS/DFSM UM/CM Department prior to the issuance of a PA number:

a. Nature, date, extent of injury/illness and initial therapy evaluation,
b. Treatment plan, including specific services/modalities of each therapy, and
c. 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 Utilization Management/Care Management Dept. (UM/CM) 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 criteria match includes:

- Provider ID
- Member 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.

For ALTCS service codes and applicable units of service please see the AHCCS Medical Coding Resource webpage.

ALTCS Dental Services

Effective date of service 10/1/2017, in accordance with A.R.S. 36-2907, an emergency dental benefit has been granted to members 21 years of age and older in an annual amount not to exceed $1,000.00 per member per contract year (October 1st to September 30th) for emergency dental care and emergency extractions. This benefit is in addition to the $1,000.00 benefit already available to ALTCS members. See AMPM Policy 310-D1 Dental Services for Members 21 Years of Age and Older.

Effective date of service 10/01/2016, the dental benefit has been restored for ALTCS members age 21 and older for medically necessary dental services.

ALTCS members may receive medically necessary dental benefits up to $1,000.00 per member per contract year (October 1st to September 30th) for diagnostic, therapeutic and preventative care. See AMPM Policy 310-D2 ALTCS Dental Services. The dental policy for ALTCS members under age 21 is described in FFS Chapter 10 and AMPM Policy 430.

ALTCS members are eligible for services as outlined in FFS Chapter 10 and AMPM Policy 310-D1 for members age 21 and older. Services that fall into the services' limitations and exceptions as outlined in the above chapter and policy would not count towards the $1,000.00 ALTCS dental benefit limit.

The contract year limit is member specific and remains with the member if the member transfers between Managed Care Organizations or between Fee-For-Service and Managed Care. It is the responsibility of the ALTCS Contractor or the Tribal ALTCS Case Manager transferring the member to notify the receiving entity regarding the current balance of the dental benefits.

Benefit coverage and limitations include:

- Unused benefit dollars do not “carry over” into the next contract year.
- Dental services performed by Indian Health Service (IHS) or a 638 Tribal facility are also subject to the $1,000.00 limit.
- Frequency limitations and services that require prior authorization still apply.
- Dentures are covered and will count towards the $1,000.00 limit.
- General anesthesia will be covered and will count towards the $1,000.00 limit.
- Physician performing general anesthesia on an ALTCS member for a dental procedure will be covered and will count towards the $1,000.00 limit.

In rare instances an ALTCS member may have an underlying medical condition that necessitates that services provided under the ALTCS dental benefit be provided in an Ambulatory Surgical Center (ASC) or an outpatient hospital and may require general anesthesia. In those instances, the facility and anesthesia charges are subject to the $1,000.00 limit.

Informed Consent

Please refer to AMPM 310-D2 Arizona Long Term Care System Adult Dental Services for further information regarding informed consent requirements.

Notification Requirements for Charges to Members

Please refer to AMPM 310-D2 Arizona Long Term Care System Adult Dental Services for further information regarding notification requirements for charges to members.

Billing for ALTCS Dental Services

Dentists will bill on the ADA form with the dental service codes. The ALTCS benefit will be subject to the Dental FFS Rates and Codes found at **https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/Dental.html**

Physicians performing general anesthesia will bill on the CMS 1500 with the appropriate CPT/HCPCS codes. Reimbursement will be subject to the FFS Physician fee schedule.

Ambulatory Surgical Center will bill on the CMS 1500 with the appropriate CPT/HCPCS codes and modifiers. Reimbursement will be subject to the FFS ASC fee schedule.

Outpatient facility surgical services will be billed on the UB-04 with appropriate revenue codes and CPT/HCPCS codes. Reimbursement will be subject to the FFS OPFS pricing.

Share of Cost (SOC)

ALTCS members 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 member's gross income. Calculations differ for members residing in nursing facilities and those receiving HCBS.

HCBS members have a personal needs allowance deducted from their income which usually is equal to the maximum income allowed for eligibility. Therefore, these members rarely have a SOC. Occasionally, an HCBS member 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 member may have a SOC.

Members 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 member's SOC. Because a member's income and expenses may fluctuate from month to month, SOC is calculated monthly.

ILLEGAL INCENTIVES/REMUNERATIONS

Providers offering gift cards, free lunches or other cash in kind inducements to have the member select their services are prohibited by Federal Criminal Penalties Statute 42 USC 1320a-7b(b)(2).

Among other activities not permitted, this law prohibits individuals from (knowingly and willfully) offering or paying any remuneration, whether it is cash or in kind, to anyone for the purpose of inducing that individual to order or arrange for any service or item for which payment may be made by a federal health care program, including Medicaid. The offer or payment may be direct or indirect. Such conduct is considered a felony with the possibility of imprisonment up to 5 years as well as a fine not to exceed $25,000.

Revision History

Date	Description of changes	Page(s)
11/3/22	Exhibit 21-3 Reserved. Redirecting to Medical Coding Resource Page	10 Exh 21-3

7/26/2019	Exhibit 21-3 Added – AHCCCS/ALTCS Services, Service Codes and Applicable Units of Service – This was formerly housed in AMPM Policy 1230, Exhibit 1230-1 and was transitioned to the billing manual.	Exh 21-3
5/04/2018	Clarification added to billing for case management services. It was changed from "The Tribal Contractors receive a monthly capitation for case management services,	3
	based on the number of tribal ALTCS members enrolled. All other services are provided and reimbursed on a fee for service basis," to, "The Tribal Contractors receive a monthly capitation for case management services, based on the number of tribal ALTCS members enrolled. Providers and Tribal Contractors are prohibited from billing for Case Management Services (T1016). All other services are provided and reimbursed on a fee for service basis." The word 'recipient' was changed to 'member.'	All
1/23/2018	Phone number removed	1
10/1/2017	Dental Occupational Therapy Format Changes	10-11 9 All
10/1/2016	ALTCS Dental Services eff 10/01/2016 Updated Physical Therapy limits to conform to AMPM	11-13 9
10/01/2015	New format Orthotics update eff 08/01/2015 "ICD-9" replaced with "ICD"; removed @ attachment, added as chapter Exhibit Removed @ attachment, added as chapter Exhibit	All 3 Exh 21-1 Exh 21-2
12/18/2013	Language updated per AMPM Exhibit 21-2 addresses updated	All Exh 21-2