1620-D PLACEMENT AND SERVICE PLANNING STANDARD

EFFECTIVE DATES: 02/14/96, 10/01/04, 02/01/05, 09/01/05, 01/01/06, 05/01/06, 10/01/07, 02/01/09, 03/01/10, 05/07/10, 01/01/11, 02/01/11, 05/01/12, 03/01/13, 01/01/16, 10/01/17, UPON PUBLISHING

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I. PURPOSE

This Policy applies to ALTCS E/PD, ALTCS DES/DDD (DDD) Contractors, and Fee-For-Service Tribal ALTCS; excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements for member placement and service planning.

II. DEFINITIONS

CASE MANAGERS — Arizona licensed registered nurses in good standing, social workers, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of Case Management experience, or individuals with a minimum of two years' experience in providing Case Management services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or have been determined to have an SMI.

CASE MANAGEMENT — A collaborative process, which assess, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

DESIGNATED REPRESENTATIVE — A parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client's rights and voicing the client's service needs as specified in A.A.C. R9-21-101(B).

HEALTH CARE DECISION MAKER — An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

HOME AND COMMUNITY BASED SERVICES (HCBS)

Home and Community-Based Services, as specified in A.R.S. §36-2931 and A.R.S. §36-2939.

MANAGED RISK AGREEMENT

A document developed by the Case Manager and the member/Health Care Decision Maker, which outlines potential risks to the member's health, safety, and well-being as a result of decisions made by the member or their Health Care Decision Maker regarding Long Term Care Services and Supports. The Managed Risk Agreement shall specify the alternatives offered to the member and shall document the member's choices with regard to any decisions involving placement, services, and supports. The Managed Risk Agreement shall be signed by the member and or the Health Care Decision Maker at each PCSP meeting and kept in the member's case file.

OWN HOME

A residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. 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 as a:
1. Health care institution under A.R.S. § 36-401.
2. Residential care institution under A.R.S. § 36-401.
3. Community residential setting under A.R.S. § 36-551, or
4. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9-101).

PERSON-CENTERED SERVICE PLAN (PCSP)

A written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports.

PLANNING TEAM

A defined group of individuals that shall include the member and with the member's consent, their family, Health Care Decision Maker, individual representative, Designated Representative, and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the planning team to best meet the needs and individual goals of the member.

III. POLICY

A guiding principle of the ALTCS program is that members live in the most integrated/least restrictive setting. Placement goals shall be identified through the PCSP process and cost effectiveness standards shall be met in the Home and Community Based setting.

The Case Manager is responsible for facilitating placement and services based primarily on the member's choice with additional input in the decision-making process from the member/Health Care Decision Maker/ and Designated Representative, the Case Manager's assessment, the Pre-Assessment Screening, and other members of the Planning Team.

Case Managers are prohibited from using referral agencies to identify placement options for members in lieu of the Contractor's contracted network of providers. Refer to Title 42 U.S. Code 1320a-7b.

The Case Manager shall adhere to placement and service planning standards as follows:

1. After the PCSP (refer to AMPM Policy 1620-B) is completed, the Case Manager shall discuss the cost effectiveness and availability of needed services with the member/Health Care Decision Maker.

2. In determining the most appropriate service placement for the member, the Case Manager and the member/Health Care Decision Maker and Designated Representative shall discuss the following as applicable:
   a. The member's placement choice and preferences,
   b. Services necessary to meet the member's needs in the most integrated/least restrictive setting. Refer to AMPM Chapter 1200 for information about the following types of services available:
      i. Home and Community Based Services (HCBS),
      ii. Institutional services,
      iii. Acute care services, and
      iv. Behavioral health services.
   c. The member's interest in and ability to direct their own supports and services. If the member is unable to direct their own supports and services, a Health Care Decision Maker or Individual Representative may be appointed to direct the member's care. Member directed options for service delivery of designated services are specified in AMPM Policy 1310-A,
   d. The availability of HCBS in the member's community,
   e. Cost effectiveness of the member's placement and service choice,
   f. Covered services which are associated with care in a nursing facility compared to services provided in the member's home or another Alternative HCBS setting as specified in AMPM Section 1230,
   g. The risks that may be associated with the member/Health Care Decision Maker's choices and decisions regarding services, placements, caregivers, which would require a Managed Risk Agreement signed by the member/ Health Care Decision Maker to document the situation,

h. If a Managed Risk Agreement is required and the member or the member's Health Care Decision Maker refuses to sign the Managed Risk Agreement, the agreement shall be placed in the case file with documentation of the refusal,
i. The member's Share of Cost (SOC) responsibility. The SOC is the amount of the member's income that the member shall pay towards the cost of long-term care services. The amount of the member's SOC is determined and communicated to the member by the local ALTCS Eligibility office,
j. The member's Room and Board (R&B) responsibility, including the following:
    i. The portion of the cost of the care in an Alternative HCBS setting that shall be paid by the member or other source such as the member's family, because AHCCCS is prohibited from covering R&B in these settings,
    ii. The monthly R&B amount is determined by, and will be communicated to the member by, the ALTCS Contractor, and
    iii. Once the member has selected an Assisted Living Facility placement option and prior to the member residing in the facility, review and signature by all parties of the Assisted Living Facility Residency Agreement is required. Refer to AMPM Chapter 1600 Exhibit 1620-15. Review and completion by the Contractor of the Assisted Living Facility Member Financial Change Agreement is required, when appropriate, to update the R&B amount whenever the member's income or facility rate changes. Refer to AMPM Chapter 1600 Exhibit 1620-16.

3. Any member who lives in their Own Home shall be allowed to remain in their Own Home as long as HCBS are cost effective. Members cannot be required to enter an Alternative HCBS placement/setting that is "more" cost effective.

4. Members shall be informed that they have the choice to select their spouse to be the member's paid caregiver for medically necessary and cost effective services (provided the spouse meets all the qualifications as specified in the attendant care section of AMPM Policy 1240.) The Case Manager shall be available to assist member/spouse with this decision but is not expected to contact the applicable agencies for the member to determine the impact of the change in the spouse's income on eligibility for programs. The Spouse Attendant Care Acknowledgement of Understanding form (AMPM Chapter 1600 Exhibit 1620-12) shall be signed by the member and spouse prior to the authorization of the member's spouse as the paid caregiver and at least annually thereafter.

5. Upon the member's/Health Care Decision Maker's agreement to the PCSP, the Case Manager is responsible for coordinating the services with appropriate providers.

   A provider's compliance with the U.S. Department of Labor, Fair Labor Standards Act, has no bearing on a member's assessed needs and corresponding authorized services and service hours.

   Placement within an appropriate setting and/or all services to meet the member's needs shall be provided as soon as possible. A decision regarding the provision of services requested shall be made within 14 calendar days following the receipt of the request/order (three business days if the member's life, health or ability to attain,

maintain or regain maximum function would otherwise be jeopardized). Refer to Title 42 CFR 438.210 for more information.

Services determined to be medically necessary for a newly enrolled member shall be provided to the member within 30 calendar days of the member's enrollment. Services for an existing member shall be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

Contractors shall develop a standardized system for verifying and documenting the delivery of services with the member/Health Care Decision Maker after authorization.

6. The Case Manager shall ensure that the member/Health Care Decision Maker understands that some long-term care services (such as home health services or Durable Medical Equipment [DME]) shall be prescribed by the PCP. A decision about the medical necessity of these services cannot be made until the PCP writes an order for the service. All orders for medical services shall include the frequency, duration, and scope of the service(s) required, when applicable.

7. If an ALTCS member does not have a PCP or wishes to change PCP, it is the Case Manager or designated staff's responsibility to coordinate the effort to obtain a PCP or to change the PCP.

8. The Case Manager shall also verify that the needed services are available in the member's community. If a service is not currently available, the Case Manager shall substitute a combination of other services in order to meet the member's needs until such time as the desired service becomes available (for example, a combination of personal care or home health aide and homemaker services may substitute for attendant care). A temporary alternative placement may be needed if services cannot be provided to safely meet the member's needs.

9. The Case Manager is responsible for developing The PCSP utilizing AMPM Chapter 1600 Exhibit 1620-10. The PCSP shall identify the member's strengths, goals, preferences, needs, and desired outcomes. The role of the Planning Team in developing the PCSP is to support the member in communicating their vision for the future. The PCSP shall include the full range of assessed services and supports identified to assist the member in achieving their established goals. For each ALTCS covered service, the PCSP shall document the frequency/quantity of the service including any change to the service since the last PCSP meeting. Every effort shall be made to ensure the member/Health Care Decision Maker understands the PCSP, including if the member/Health Care Decision Maker agrees or disagrees with each service authorization. The Case Manager shall engage the Contractor in reasonable conflict resolution efforts to resolve issues related to member's disagreement with the PCSP.

The PCSP shall be reviewed according to the timeframes specified in AMPM Chapter 1600 Exhibit 1620-1 or sooner if there is a change to the member's functional needs, circumstances, individual goals, or at the member's request. If the member is physically unable to sign, the Case Manager shall document how the member

communicated their agreement/disagreement. If the member is unable to participate due to cognitive limitations and the member does not have a Health Care Decision Maker, the Case Manager shall leave the PCSP unsigned and document the circumstances. The Case Manager shall provide a copy of the PCSP to the member/Health Care Decision Maker and maintain a copy in the case file. The Case Manager shall also provide a copy of the PCSP to the individuals selected by the member/Health Care Decision Maker, as specified in the PCSP.

The Case Manager shall assess for risks, while considering the member's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve individual goals.

10. If the member/Health Care Decision Maker disagrees with the PCSP and/or authorization of placement/services (including the amount and/or frequency of a service), the Case Manager shall provide the member/Health Care Decision Maker with a Notice of Adverse Benefit Determination (NOA) that explains the member's right to file an appeal regarding the placement or PCSP determination. In addition to the grievance and appeals procedures described above, the Contractor shall also make available the grievance and appeals processes as specified in 9 A.A.C 21 Article 4, ACOM Policy 444, and ACOM Policy 446 for persons determined to have a Serious Mental Illness (SMI) under Arizona law refer to Inter Governmental Agreement.

    Contractors shall ensure that all issues presented by the member in the appeal are fully addressed and explained in the Notice of Appeals Resolution (NAPR). It is further expected that the Contractor shall communicate with the member's provider(s) before issuing the NAPR to ensure the Contractor has thorough, timely, and accurate information to adjudicate the appeal. For service-related decisions in which the appeal is not upheld, the NAPR shall clearly explain the specific treatment alternatives and services that are available for the member to consider such as step therapies or more cost effective, clinically appropriate treatment alternatives. Upon receipt of a request for hearing, Contractors are required to thoroughly review their determination to ensure that the decision is complete, is legally and factually accurate as well as relevant to the appealed matter, and that it supports the Contractor's determination. The Contractor shall also promptly evaluate any new information that is submitted with the request for hearing. Sufficiently in advance of the date of the hearing, the Contractor shall contact the member to explain the reasons for the Decision and make reasonable efforts to resolve the member's concerns outside of the hearing process.

11. The ALTCS Member Contingency/Back-Up Plan (AMPM Chapter 1600 Exhibit 1620-14) shall also be completed for those members who will receive any of the following critical services in their Own Home:
    a. Attendant care, including spouse attendant care, Agency with Choice and Self-Directed Attendant Care,
    b. Personal care, including Agency with Choice,
    c. Homemaker, including Agency with Choice and/or
    d. In-home respite.

The term "critical services" is inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.

A gap in critical services is defined as the difference between the number of hours of critical services scheduled in each member's PCSP and the hours of the scheduled type of critical services that are actually delivered to the member.

The following situations are not considered gaps:

a. The member is not available to receive the service when the Direct Care Worker (DCW) arrives at the member's home at the scheduled time,
b. The member refuses the DCW when he/she arrives at the member's home, unless the DCW's ability to accomplish the assigned duties is significantly impaired by the DCW's condition or state (for example, drug and/or alcohol intoxication),
c. The member refuses services,
d. The provider agency or Case Manager is able to find an alternative DCW for the scheduled service when the regular DCW becomes unavailable,
e. The member and regular DCW agree in advance to reschedule all or part of a scheduled service, and/or
f. The DCW refuses to go or return to an unsafe or threatening environment at the member's residence.

The contingency plan shall include information about actions that the member/Health Care Decision Maker and Designated Representative should take to report any gaps and what resources are available to the member, including on-call back-up DCWs and the member's informal support system, to resolve unforeseeable gaps (e.g. regular caregiver illness, resignation without notice, transportation failure) within two hours. **The informal support system shall not be considered the primary source of assistance in the event of a gap, unless this is the member's/family's choice.** An out-of-home placement in a Nursing Facility (NF) or Assisted Living Facility (ALF) should be the last resort in addressing gaps.

The contingency plan shall include the telephone numbers for the toll-free AHCCCS line and provider and/or Contractor that will be responded to promptly 24 hours per day, seven days per week. The member/HealthCare Decision Maker should be encouraged to call the toll-free AHCCCS line and provider and/or Contractor so that the service gap can be responded to in a timely manner.

In those instances where an unforeseeable gap in critical services occurs, it is the responsibility of the Contractor to ensure that critical services are provided within two hours of the report of the gap. If the provider agency or Case Manager is able to contact the member/Health Care Decision Maker before the scheduled service to advise the member/Health Care Decision Maker that the regular caregiver will be unavailable, the member/Health Care Decision Maker may choose to receive the service from a back-up substitute caregiver, at an alternative time from the regular caregiver or from an alternate caregiver from the member's informal support system.

The member/Health Care Decision Maker has the final say in how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.

12. The written contingency plan for members receiving those critical services described above shall include a Member Service Preference Level from one of the four categories shown below:
    a. Needs service within two hours,
    b. Needs service today,
    c. Needs service within 48 hours, or
    d. Can wait until the next scheduled service date.

    Member Service Preference Levels shall be developed in cooperation with the member /Health Care Decision Maker and Designated Representative and are based on the most critical in-home service that is authorized for the member. The Member Service Preference Level will indicate how quickly the member/Health Care Decision Maker chooses to have a service gap filled if the scheduled caregiver of that critical service is not available. The member/Health Care Decision Maker shall be given the final say about how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.

    The Case Manager shall assist the member/Health Care Decision Maker in determining the member's Service Preference Level by discussing the member's caregiving needs associated with the member's Activities of Daily Living (ADL), such as mobility, transferring, toileting, bathing, grooming, and eating and Instrumental Activities of Daily Living (IADL), such as housekeeping, meal preparation and grocery shopping, abilities and cognitive, behavioral and medical status. The Case Manager should ensure the member/Health Care Decision Maker has considered all appropriate factors in deciding the member's Service Preference Level. The member/Health Care Decision Maker is not required to take into account the presence of an informal support system when determining the Service Preference Level.

    The Case Manager shall document the Member Service Preference Level chosen in the case file. This documentation shall clearly indicate the member's/Health Care Decision Maker's involvement in contingency planning.

    The member/Health Care Decision Maker can change the Service Preference Level from a previously determined Service Preference Level at the time of the service gap, depending on the circumstances at the time. The provider agency or Contractor shall discuss the current circumstances with the member/Health Care Decision Maker at the time the gap is reported to determine if there is a change in the Service Preference Level. The plan to resolve the service gap shall address the **member's**/Health Care Decision Maker's **choice** at the time the gap is reported.

    The contingency plan shall be discussed with the member/Health Care Decision Maker at least quarterly. A copy of the contingency plan shall be given to the member/Health Care Decision Maker when developed and at the time of each review

visit. The member/Health Care Decision Maker may change the member Service Preference Level and their choices for how service gaps will be addressed at any time.

13. Members who reside in "Own Home" settings should be encouraged and assisted, as indicated, by the Case Manager to have a disaster/emergency plan for their household that considers the special needs of the member. Case Managers shall document the discussion with the member/Health Care Decision Maker. Informational materials are available at the Federal Emergency Management Agency's (FEMA) website at www.fema.gov or www.ready.gov.

14. Members who reside in out-of-home residential placements shall be regularly assessed to determine if they are in the most integrated setting possible for their needs. Members are permitted to change to a less restrictive placement, as long as needed services are available and cost effective in that setting.

15. If the member will be admitted to a nursing facility, the Case Manager shall ensure and document that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and Level II evaluation, if indicated, have been completed prior to admission. Refer to AMPM Policy 680-C for more information.

16. If the member/Health Care Decision Maker does not intend to pursue receiving HCBS or institutional services, the Case Manager shall review the ALTCS member handbook and inform the member/Health Care Decision Maker on the process for voluntary withdrawal, and guide the member/Health Care Decision Maker on seeking services through an AHCCCS Acute Care Contractor or other programs.

    If the member refuses long term care services that have been offered or refuses to allow the Case Manager to conduct a review visit in accordance with the required timeframes and locations, but does not wish to withdraw from the ALTCS program, the case shall be referred for an evaluation of Acute Care Only eligibility via the electronic Member Change Report (EMCR) process. The member/Health Care Decision Maker shall be advised that the member may be disenrolled from the ALTCS program depending on the member's income. The EMCR and documentation that further describes the circumstances of the member's refusal to accept ALTCS services should be sent to the AHCCCS/Division of Health Care Management (DHCM) Medical Management (MM) Unit.

    Refer to AMPM Chapter 1600 Exhibit 1620-2 for a hard copy of the MCR form. AMPM Chapter 1600 Exhibit 1620-2 also provides guidelines on circumstances for which an EMCR is needed and AMPM Chapter 1600 Exhibit 1620-4 describes and gives examples of member situations for which an Acute Care Only "D" placement is appropriate.

17. The PCSP shall include the date range and units for each service authorized in the member's case file according to the Contractor's system for tracking service authorizations. Tribal ALTCS Programs Case Manager shall enter those services authorized for the member on the CA165/Service Plan in the CATS system.

For members residing in an institutional setting, the Contractor's system for tracking authorized services or the CA165/Service Plan (for Tribal ALTCS Programs) shall include the following types of services, as appropriate based on the member's needs:

a. Nursing facility services. The PCSP shall indicate the Level of Care (Level I, II, or III) based on the Uniform Assessment Tool or other contractor method for determining specialty care (for example, behavior management, wandering/ dementia or sub-acute),
b. Hospital admissions (acute and psychiatric),
c. Bed hold or therapeutic leave days (refer to AMPM Policy 100 for definitions and limitations),
d. Services in an uncertified nursing facility,
e. DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless if rented, purchased or repaired). This requirement is waived for ALTCS/DDD members,
f. Hospice services,
g. Therapies (occupational, physical and speech),
h. Medically necessary non-emergency transportation **(required for Tribal ALTCS Programs only),**
i. Behavioral health services (only those provided by behavioral health independent billers – see definition in the Glossary of the Behavioral Health Services Guide), and
j. Title XIX covered services as noted above if provided by other funding sources, for example, Medicare, Tribes, Children's Rehabilitative Services, other insurance sources.

18. For members residing in an HCBS setting the Contractor's system for tracking authorized services or the CA165/Service Plan (for Tribal ALTCS Programs) shall include the following types of services, as appropriate, based on the member's needs:
    a. Adult day health or group respite,
    b. Hospital admissions (acute and psychiatric),
    c. Attendant care – including when provided through a member directed option. One or more service code modifiers shall be used to distinguish the type of Attendant Care when /if provided as follows:
        i. By the member's spouse (U3),
        ii. By family living with the member (U5),
        iii. By family not living with the member (U4),
        iv. As Self Directed Attendant Care (U2), and/or
        v. As Agency with Choice (U7),
    d. DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless if rented, purchased or repaired). This requirement is waived for ALTCS/DDD members,
    e. Emergency alert systems,
    f. Medical supplies that have a monthly cost in excess of $100.00 (**required for Tribal ALTCS Programs only**),
    g. Habilitation, including when provided through a member directed option. The U7 service code modifier shall be used to designate when the service is provided as Agency with Choice,
    h. Home delivered meals,

i. Home health aide,
j. Community Transition Services that will be authorized in order to transition the Nursing Facility (NF) member to HCBS "Own Home". Refer to AMPM Policy1240-C for definitions and limitations. This service may be authorized while the member is still in an institutional placement,
k. Homemaker, including when provided through a member directed option. The U7 service code modifier shall be used to designate when the service is provided as Agency with Choice,
l. Hospice,
m. Personal care, including when provided through a member directed option. The U7 service code modifier shall be used to designate when the service is provided as Agency with Choice,
n. Respite care, including nursing facility respite,
o. Therapies (occupational, physical, speech, and/or respiratory),
p. Behavioral health services (only those that are authorized with Healthcare Common Practice Coding System [HCPCS] codes),
q. Medically necessary non-emergency transportation when the round trip mileage exceeds 100 miles (**required for Tribal ALTCS Programs only**),
r. Home modifications,
s. Assisted Living Facility services,
t. Member and/or DCW Training, authorized as part of a member directed service option,
u. Behavioral health alternative residential facility services, and
v. Title XIX covered services as noted above, if provided by other funding sources, for example, Medicare, Tribes, Children's Rehabilitative Services, other insurance sources.

19. For members designated as **"Acute Care Only (ACO)"** the Contractor's system for tracking authorized services or the CA165/Service Plan (for Tribal ALTCS Programs) shall include the following types of services, as appropriate, based on the member's needs:
    a. DME (this requirement is waived for ALTCS/DDD members),
    b. Medically necessary non-emergency transportation when the round trip mileage exceeds 100 miles (required for Tribal ALTCS Programs only),
    c. Rehabilitative therapies (physical, occupational and speech), and
    d. Behavioral health services.

    Members who are enrolled as "ACO" due to financial reasons (such as a transfer of resources) are eligible to receive all medically necessary behavioral health services as listed in AMPM Policy 310-B.

20. Refer to AMPM Chapter 1200 for descriptions of the amount, duration, and scope of ALTCS services and settings, including information about restrictions on the combination of services.

21. The CA161/Placement Maintenance screen in the Client Assessment Tracking System (CATS) system shall be updated with the following information within 10 business days of the initial PCSP meeting:
    a. ID number of Case Manager currently assigned to the case,

b. Date of last Case Management review visit with the member,
c. Placement code(s) and begin/end dates since enrollment,
d. Residence code that corresponds with each Placement,
e. Placement Reason code that corresponds with each Placement, and
f. Behavioral health code that reflects member's current status.

Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management for information on the codes and procedures for entering the above data into the CATS system.

22. The CA162/Community First Choice screen in the Client Assessment Tracking System (CATS) shall be entered with the following member information within ten business days of the PCSP meeting and updated at least annually:
    a. Agency With Choice indicator,
    b. Self-Directed Attendant Care indicator,
    c. Employment Status,
    d. Educational Level,
    e. Level of Care,
    f. Incontinence Status,
    g. Whether member receives any Antipsychotic Medications, and
    h. Major Diagnosis (at least one but up to three diagnoses).

    Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management for information on the codes and procedures for entering the above data into the CATS system.

23. Contractors are not required to enter service authorizations on the CA165/Service Plan in the CATS system. Tribal ALTCS Programs are required to enter this information on the CA165/Service Plan within five business days of the initiation of the service(s) authorized.

    Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management, for information on the codes and procedures for entering service plan data into the CATS system.