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

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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 elderly and/or have physical disabilities and to members who are determined to have Developmental Disabilities (DD) who require an institutional level of care (this term is also referred to as at immediate risk of institutionalization). The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning 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 an alternative residential setting versus entering or remaining in an institution.

Members are those individuals who are eligible for ALTCS services and enrolled with an ALTCS Contractor, the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) or a Tribal Contractor. All services provided to ALTCS members with DD are provided through ADES/DDD. Managed Care Contractors provide long term care services within their network. Tribal Contractors authorize long term care services through a FFS network. 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, ADES/DDD 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 settings in which HCB and institutional services may be provided. Service providers must be appropriately licensed, registered or certified by a State governing board or agency and must be registered as an AHCCCS provider. To serve members enrolled with a Managed Care Contractor, including ADES/DDD, service providers, with certain limited exceptions, must also be contracted with the Contractor.

Each ALTCS member is assigned a case manager, through the Contractor, 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 Section 1115 Waiver from the Centers for Medicare and Medicaid Services (CMS). Contractors are encouraged by AHCCCS to, whenever possible, serve members in their own home or assist members with placement in HCB alternative settings. The cost of room and board in an HCB setting is not covered by ALTCS.

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 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)

Elderly or physically disabled American Indians who are living "on-reservation" or who have lived on a reservation prior to admission into an off-reservation nursing facility and have been determined eligible for the ALTCS program are enrolled with an ALTCS Tribal Contractor. Tribal Contractors, through assigned tribal case managers, are responsible for providing case management services and for authorizing certain services, including most ALTCS HCBS and institutional services.

Although the Tribal Contractor is responsible for authorizing many ALTCS services, there are specific services that may only be authorized by the AHCCCS Administration through the Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU). AHCCCS reimburses the services through its FFS ALTCS Program whether the services are authorized by the Tribal Contractor or the DFSM CMSU Unit (Tribal Contractors provide the assessment and authorization for services only. They do not reimburse the provider for services). Some services do not require prior authorization.

These services include emergency services (medical and behavioral health), and EPSDT services, including dental, for members under age 21.

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

Licensing 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. Registration of these 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 Providers

Services provided outside the State of Arizona, by out-of-state service providers, are covered as provided for under Title 42 of the Code of Federal Regulations (42 C.F.R.), 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 of the United States are not covered. AHCCCS will not register providers who are located outside of the United States.

NOTE: "United States" (U.S.) is as defined in Chapter 300 of this Manual.

Exhibits/Appendices

The following Exhibits can be found at the end of each policy in this Chapter. 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 persons with intellectual disabilities.

2. Exhibit 1210-2 lists the 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 1240-1 identifies medical supplies included in the FFS rate for home health nursing visits.

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

6. Exhibit 1240-3 provides a copy of the AHCCCS/ALTCS FFS Home Modification Request/Justification form.

7. Exhibit 1250-1 identifies whether service authorization is to be obtained from the case manager or, if PCP orders are required, for the various components of ALTCS services.

8. Exhibit 1250-2 provides a table of ALTCS services, service codes and applicable units of service,

9. Appendix J contains information and the required form for mileage reimbursement for independently registered FFS providers of certain in-home services.

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 C.F.R.) 483.108, 483.114, 483.116, 483.118, 483.120 (PASRR)

2. 42 C.F.R., 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 C.F.R., 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 C.F.R., 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

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Description

AHCCCS/ALTCS covers medically necessary institutional services provided in an AHCCCS registered long term care facility for ALTCS members who are at immediate risk of institutional placement and 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).

Services provided to managed care Title XIX members (including members who receive behavioral health services through an Integrated RBHA, RBHA or TRBHA) may be reimbursed in any behavioral health setting, regardless of age, under the Federal Provision, 42 C.F.R. 438.6(e), when approved for managed care contracts by CMS.

NOTE: ALTCS members who are in the transitional program (see detailed information about the transitional program in Policy 1620, Standard H of this manual) are not eligible for Nursing Facility (NF) services or Intermediate Care Facility for persons with intellectual disabilities (ICF) services exceeding 90 continuous days per admission. Also, services outlined in Policy 1240 of this Chapter may not be provided in institutional settings.

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 C.F.R. 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 Persons with Intellectual Disabilities (ICF)

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 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 of this Manual) 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 of this Manual. Medical/acute care services provided to ALTCS members are the same as those provided to acute care 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 the Behavioral Health Services Guide). Refer to the ADHS/Health Services Guide for further information on AHCCCS covered behavioral health services and settings.

5. Hospice services (refer to Policy 1250 of this Manual 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 Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities. ALTCS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual.

Behavioral Health Inpatient Facility

A behavioral health service facility licensed by ADHS, as defined in 9 A.A.C. 10-101, 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. Some BH Inpatient 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 members is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Inpatient facilities with more than 16 beds are considered IMDs.

AHCCCS will suspend eligibility for persons over age 21 and under age 65 while the member is admitted to an IMD when:

1. The member is an ALTCS eligible person whose care is covered fee-for-service (that is, the member is not enrolled with an ALTCS managed care contractor), or

2. The member is enrolled with a managed care contractor responsible for providing coverage for behavioral health services (an Integrated RBHA, RBHA, TRBHA, or ALTCS managed care contractor) and the IMD is owned or operated by the Indian Health Service or a tribal entity under a 638 agreement with the Indian Health Service.

However, eligibility will not be suspended for persons under the age of 22 if they are patients in an IMD when they turn age 21.

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. An AIHP/FFS or Tribal ALTCS 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. Physical health and 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 a behavioral health 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 the ADHS/Behavioral Health Services Guide).

Refer to the ADHS/Behavioral Health Services Guide 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 PERSONS WITH INTELLECTUAL DISABILITIES FEE-FOR-SERVICE PER DIEM RATE

EXHIBIT 1210-1

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

Under 9 A.A.C. 22, Article 2, DME is included in the per diem rate of NFs and ICFs/ID. 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)
Manual wheelchairs (all non-customized)
Nebulizers
Lifts
Suction machines
IV poles
Walkers (all non-customized)
Water mattress

Customized DME (as defined in Chapter 100 of this Manual) 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 Care Management Systems Unit (CMSU) 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, member 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

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.

1220-A RESIDENT ASSESSMENT

REVISION DATES: 07/01/12, 10/01/07, 03/01/06, 10/01/01, 02/01/01, 03/14/97

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1. NF providers must complete a resident assessment for each resident within 14 days of admission, using an approved Resident Assessment Instrument (RAI). The 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.

1220-B NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM

REVISION DATES: 10/01/07, 03/01/06, 10/01/04, 10/01/01, 02/01/01, 03/14/97

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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.

1220-C PRE-ADMISSION SCREENING AND RESIDENT REVIEW

REVISION DATES: 07/01/12, 10/01/07, 03/01/06, 10/01/04, 10/01/01, 02/01/01, 03/14/97

INITIAL
EFFECTIVE DATE: 02/14/1996

1. AHCCCS registered NFs must complete 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 ID 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 of this section for MI or #7 for MR.

2. ALTCS 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 consecutive days, however a PASRR Level I screening is still required but a referral for a Level II evaluation is not needed. If it is later determined that the admission will last longer than 30 consecutive days, however, a new Level I PASRR screening must be completed as soon as possible to determine if a Level II evaluation is indicated. 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. 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 enrolled members are appropriate for a nursing level of care as determined by the ALTCS Pre-Admission Screening (PAS) tool for medical eligibility. If an individual is admitted and is 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 ADES/DDD 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 ADHS 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 an 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)

EXHIBIT 1220-1
PASRR SCREENING DOCUMENT
LEVEL I

ARIZONA HEALTH CARE
COST CONTAINMENT SYSTEM

A. MEMBER INFORMATION

1) NAME: last, first
_____

2) DATE OF BIRTH: _____/_____/_____

3) AHCCCS ID #: _____

4) MEMBER 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 intellectual disabilities 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 RETARDED (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
- Intellectual disabilities

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 V as:

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

and
Level of impairment limiting life activities within the past three to six 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 MEMBER 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.

_____ _____
MEMBER OR MEMBER'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 member screening.

_____ _____
SIGNATURE TITLE

_____ _____/_____
PRINT NAME TELEPHONE NUMBER DATE

Revision Date: 03/2006
Review Date: 07/2012

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 member must not be admitted to a Medicaid certified nursing facility until the Level II portion of the evaluation process has been completed.

A. MEMBER 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 MEMBER'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 MEMBER OR REPRESENTATIVE

READ THE DISCLOSURE TO THE MEMBER 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.

1230 HOME AND COMMUNITY BASED SERVICE SETTINGS

REVISION DATES: 07/01/12, 10/01/07, 06/01/07, 03/01/06, 07/01/04, 10/01/01, 07/01/99

INITIAL
EFFECTIVE DATE: 02/14/1996

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 1250-2 to view the table of settings and service codes.

1230-A ASSISTED LIVING FACILITIES

REVISION DATES: 10/01/13, 05/01/13, 03/01/13, 07/01/12, 10/01/07, 06/01/07, 03/01/06, 07/01/04, 10/01/01, 07/01/99

INITIAL
EFFECTIVE DATE: 02/14/1996

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 8. ALFs are designed for ALTCS members who are physically or functionally unable to live in their own home, 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:

1. 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.

2. Assisted Living Home (ALH) The facility provides resident rooms and services to ten or fewer residents.

3. Adult Foster Care Home The facility provides Adult Foster Care (AFC) services for at least one and no more than four adult residents, who are participants in the ALTCS program. 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 or 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 and must be paid by the member or his/her family or representative.

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. Please note that Assisted Living Facilities are required by licensure standards and by State regulation (R9-10-808) to provide residents with adequate recreation and socialization opportunities.

Refer to Policies 1240 and 1250 of this Chapter for a description of these services, and any limitations to ALTCS coverage.

Refer to Chapter 1600 of this Manual for information regarding and a copy of the ALF Residency Agreement used by case managers to outline the ALTCS standards for Assisted Living services.

1230-B BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

REVISION DATES: 10/01/13, 07/01/12, 10/01/07, 06/01/07, 03/01/06, 10/01/01, 07/01/99

INITIAL
EFFECTIVE DATE: 02/14/1996

Description

The following behavioral health residential 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 residing in one of the following behavioral health residential facilities:

1. Behavioral Health Residential Facility – Licensed by Arizona Department of Health Services (ADHS). An HCB alternative residential behavioral health treatment setting that provides treatment to an individual experiencing a behavioral health issue that:

    a. Limits the individual's ability to be independent, or

    b. Causes the individual to require treatment to maintain or enhance independence.

2. Adult Behavioral Health Therapeutic Home – Licensed by Arizona Department of Health Services (ADHS). A behavioral health supportive home that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to case manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issues and need for behavioral health services.

3. Children's Behavioral Health Respite Home – Licensed by Arizona Department of Health Services (ADHS). A behavioral health supportive home where respite services are provided to an individual under 18 years of age based on the individual's behavioral health issue and need for behavioral health services and includes assistance in the self-administration of medication.

4. Substance Abuse Transitional Facility – Licensed by Arizona Department of Health Services (ADHS). A health care institution that provides behavioral

health services to an individual who is intoxicated or who may have a substance abuse problem.

Amount, Duration and Scope

ALTCS members are eligible to receive AHCCCS covered medically necessary behavioral health services. Services provided in behavioral health facilities are based on a per diem rate for a 24-hour day. Room and board is not a covered service for Behavioral Health Residential Facilities, behavioral health supportive homes or substance abuse transitional facilities. The room and board amount is determined by the ALTCS Contractor and must be paid by the member or his/her family or representative. Refer to the section on behavioral health services included in Chapter 300, Policy 310 of this Manual, for a listing of services included in the comprehensive service package.

1230-C COMMUNITY RESIDENTIAL SETTINGS

REVISION DATES: 07/01/12, 10/01/07, 06/01/07, 03/01/06, 10/01/01, 07/01/99

INITIAL
EFFECTIVE DATE: 02/14/1996

Description

Community residential settings:

1. Are licensed by the Arizona Department of Economic Security to provide room, board, personal care, supervision and coordination of habilitation and treatment. There are three types.

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

    c. Group homes: a residential facility for no more than six members.

    NOTE: Group homes are licensed by Arizona Department of Health Services for health and safety and monitored by the Contractor for programmatic compliance.

Community residential 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. The room and board amount is determined by the ALTCS Contractor and must be paid by the member or his/her family or representative.

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 descriptions 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.

1240 HOME AND COMMUNITY BASED SERVICES

REVISION DATES: 10/01/14, 07/01/12, 02/01/11, 10/01/07, 03/01/07, 12/01/06, 06/01/06, 03/01/06, 10/01/01, 07/01/99

INITIAL
EFFECTIVE DATE: 02/14/1996

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.

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, of this Manual 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 case file by the member's case manager.

None of the home-based services described in this policy may be provided and/or claimed separately while the member is in an inpatient setting.

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. Fee-For-Service (FFS) Tribal affiliated providers must meet AHCCCS requirements through attestation by the Tribal government.. Those categories of authorized ALTCS service provider types 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 FFS members.

A person who assists an elderly person or an individual with a disability with activities necessary to allow them to reside in their own home must be employed by a provider agency, or in the case of member-directed options (as outlined in Chapter 1300 of this policy), by ALTCS members in order to provide services (attendant care, personal care, homemaker, respite or habilitation services) to ALTCS Members. The provider agency or ALTCS member, in the case of member-directed options, establishes terms of employment.

Supervisory Visits Applicable to all Homemaker, Personal Care, and Attendant Care Agencies

Homemaker, personal care and attendant care agencies are required to perform periodic supervisory visits to assess and document the employee's competency in performing the assigned duties in a safe manner, as ordered and according to the training the employee has received. Supervisory visits must be documented in the member's case file and cross-referenced in the employee's personnel file. There are distinct timeframes for these visits, as well as instances when the employee must be present and circumstances when they do not need to be present. Therefore, the primary documentation is maintained in the member's file with a cross-reference to the employee's file.

When the agency determines through supervisory visits or other oversight activities that services were not provided as authorized, the reasons for the non-provision of services must be documented by the provider in the member's case file and reported to the Program Contractor. The Program Contractor must be notified if any potential fraud is suspected (e.g., timesheet fraud by employee and/or member/representative).

1. Supervisory visits requiring the employee's presence

   Some supervisory visits must be performed while the employee is providing services, in order to observe the care being provided. 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 more frequent visits are warranted. These visits may be combined with Item 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 Item 1 above as determined applicable.

   NOTE: The timing of these supervisory visits for the first 90 days is based on the date of the initial service provision, and not the date of the initial service referral/ authorization. After the first 90th day visit, all other 90 day visits occur at least every 90 days from the previous visit.

   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.

i. From the date of initial service provision and for the next 90 days, supervisory visits are required by the 5th day, 30th day, 60th day (is only required if issues are identified) and 90th day.
ii. The 5th day visit shall not occur on the day of the initial service provision. The 30th, 60th and 90th day visits must occur within 5 days of their due date.
iii. After the initial 90th day visit, all other visits occur at least every 90 days from the previous visit. The every 90 day visits must not occur more than five days after their due date.
iv. Home Health Agency visits are in accordance with 9 A.A.C. 10, Article 12.

Supervisory Visit Table: Example:

PROVISION OF SERVICE DATE: 05/01/2010	
TYPE OF VISIT	OPTIMAL VISIT DATE
5 Day	05/06/2010
30 Day	05/31/2010
60 Day	06/30/2010 (only if needed)
90 Day	07/30/2010
2nd 90 Day	10/28/2010
3rd 90 Day	01/26/2011

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. The supervisory visit requirements are the same as "A" in this section except that the 5th day visit, depending on the nature of the care being performed, can be made by telephonic contact.

1240-A DIRECT CARE SERVICES

(ATTENDANT CARE, PERSONAL CARE, AND HOMEMAKER SERVICES)

PREVIOUSLY LOCATED IN 1240-B, 1240-J, 1240-H

REVISION DATE: 10/01/14, 10/01/13, 03/01/13

INITIAL
EFFECTIVE DATE: 10/01/2012

Overview

AHCCCS covers direct care services, known as Attendant Care, Personal Care, and Homemaker services, for Arizona Long Term Care System (ALTCS) members who require assistance to meet their needs and allow them to reside in their own home. These services are provided by Direct Care Workers (DCW) and enable members who might otherwise be in a nursing facility or Home and Community Based Services (HCBS) 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. Services are designed to assist individuals in acquiring, retaining and improving the self-help skills necessary to reside successfully in Home and Community Based (HCB) settings.

Definitions

1. Direct Care Services – The services provided by Direct Care Workers are collectively known as Direct Care Services. There are three types of services within ALTCS that are provided by Direct Care Workers; these include Attendant Care, Personal Care, and Homemaker services. The service specifications related to each service are included in this policy Section F. Refer to Exhibit 1250-2 for codes to be utilized related to these services.

2. Direct Care Worker (DCW) – A person who assists an elderly person or an individual with a disability with activities necessary to allow them to reside in their home. These individuals, also known as Direct Support Professionals, must be employed by DCW Agencies or, in the case of member-directed options, by ALTCS members in order to provide services to ALTCS members. The DCW Agency or ALTCS member, in the case of member-directed options, establishes terms of employment.

3. Direct Care Worker Agency – An agency that registers with AHCCCS as a service provider of Direct Care Services that include Attendant Care, Personal Care or Homemaker. The agency, by registering with AHCCCS, warrants that it has the ability, authority, skills, expertise and capacity to perform the services as specified in AHCCCS policy.

4. Member-Directed Options – Member –directed options (as outlined in Chapter 1300 of this policy) allow members to have more control over how certain services are provided, including services such as attendant care, personal care, homemaker and habilitation. The options are not services, but rather define the way in which services are delivered. Member-directed options are available to ALTCS members who live in their own home. Member-directed options include Agency with Choice, Self-Directed Attendant Care and the Division of Developmental Disabilities' Independent Provider Network.

A. GENERAL REQUIREMENTS APPLICABLE TO ALL DIRECT CARE SERVICES

1. Direct 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 direct care worker, under Attendant Care, 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. Direct care services are not reimbursable in any inpatient, institutional (as described in Policy 1210 of this Chapter) or Alternative Residential (as described in Policy 1230 of this Chapter) settings.

2. DCW Agencies hire, supervise and control the responsibilities and tasks of the Direct Care Worker as well as establish the rate of reimbursement and wages. DCW Agencies are not required to be certified by a state regulatory board or agency, however, as with any AHCCCS provider, agencies mustsign sign and attest they meet the terms of the AHCCCS Provider Participation Agreement. Agencies must also ensure the basic testing, documentation, and training requirements for DCW's are satisfied as set forth in this Policy, including those involving direct care services that are provided through the Agency with Choice (AWC) option. Agencies are also responsible for assuring that employees providing services to ALTCS members comply with any additional standards established by the Contactor.. Additional information about the service requirements for AWC can be found in Chapter 1300 of this Manual.

3. 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.

As with other HCBS services, the number and frequency of authorized direct care services 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.

4. The DCW training and testing requirements included in this Policy are applicable to the DCWs who provide services through a Direct Care Worker Agency, including DCWs who provide services through the the AWC option.

5. The DCW training and testing requirements included in this Policy are **not** applicable to DCWs providing services to member's through the the Self Directed Attendant Care Services (SDAC) or to the Division of Developmental Disabilities' (DDD) Independent Provider Network member-directed options . Service requirements for SDAC can be found in Chapter 1300 of this Manual.

B. STANDARDS AND REQUIREMENTS APPLICABLE TO ALL INDIVIDUALS WHO ARE EMPLOYED AS DIRECT CARE WORKERS

1. All Direct Care Workers, including those who are family members, must comply with the following basic standards:

   a. Hold certification in Cardiopulmonary Resuscitation (CPR) and first aid.

      i. Training in CPR and first aid must be provided or sponsored by a national recognized organization.
      ii. Training sessions must be in person in order for the participant to demonstrate learned skills such as mouth-to-mouth resuscitation, chest compressions and first aid skills. Web-based training without the benefit of on-site return demonstration of skills is not acceptable.

   b. 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 DCW. The monitoring and supervision may also provide assistance with any adjustment issues between the member and the DCW. All monitoring and supervision assessments must be documented and kept in the DCW's personnel file.

c. 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 direct care service and other services, must be developed by the case manager for each member who is to receive direct care services. The DCW, or agency representative, must notify the case manager or designee of any changes in member condition.

d. Comply with the applicable Education Requirements described in Section E of this policy.

C. PROGRAM MANAGEMENT COMPONENTS APPLICABLE TO ALL AGENCIES WHO EMPLOY DIRECT CARE WORKERS

Agencies which employ Direct Care Workers, including those agencies that provide services through the AWC option, are responsible for the following. Additional information about the service requirements for AWC can be found in Chapter 1300 of this Manual:

1. Being registered as an AHCCCS provider.

2. Pre-screening all DCW applicants including contacting three references, one of whom must be a former employer, if applicable. This process must also incorporate evaluation of the appropriateness of allowing the member's relatives to provide direct care services.

3. Matching the skills of qualified DCWs with each ALTCS member's needs for Direct Care Services, 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 DCW. The agency needs to be available to assist in their 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 DCW that delineates the responsibilities of each.

4. Assuring that all DCWs hold current certification in CPR and first aid prior to providing care to an ALTCS member.

5. Providing supervisory visits of DCW as described in Section D of this Policy.

6. Verifing the delivery of DCW services, including methodologies to discourage falsification of time sheets and other records that demonstrate the type, amount, duration and frequency of services provided, and providing payment for such services within agreed upon timeframes.

7. Maintaining records which demonstrate:

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

    b. Records of DCW work verification, educational requirements and payment that are retained according to 9 A.A.C. 28, Article 5.

8. Ensuring compliance with education requirements described in Section E of this policy by either becoming an Approved Direct Care Worker Training and Testing Program or delegating the responsibility of DCW training and testing to an Approved Direct Care Worker Training and Testing Program (see AHCCCS Contractor Operations Manual, Policy 429 for approved Direct Care Worker Training and Testing Program requirements and standards). Additionally, agencies that employ DCWs must ensure compliance with training and testing records maintance standards outlined below. Non-compliance may result in contract termination and/or termination of AHCCCS provider registration.

    a. Manage and maintain individual DCW training and testing records that includes:

        i. Services provided by the DCW,
        ii. Exemptions from training and testing requirements (if applicable),
        iii. Hire date and date training period concluded,
        iv. Standard form utilized to obtain permission from DCW to access testing records in the online database,
        v. Verification of testing type(s), date(s), module(s) and score(s). Verificiation sources may include a completed Verification of Direct Care Worker Testing form from a former employer (available on the AHCCCS website (www.azahcccs.gov/dcw) or official transcript from an Approved Direct Care Worker Training and Testing Program, and
        vi. Annual timeframe, hours, topics and delivery methods for continuing education.

    b. Integrate the use of the AHCCCS DCW and trainer testing records online database into day to day business practices. The primary purpose of the online database is to serve as a tool to support the portability or transferability of DCW or trainer testing records from one employer to another employer. The database is available online at https://dcwrecords.azahcccs.gov and provides a complete computer-based training modules, a frequently asked questions document and a User Guide under the "help" tab. Employers of DCWs shall:

i. Maintain a list of organizational users and notify AHCCCS when a user account must be terminated or suspended
ii. Maintain and manage a list of employees who will be or have been sent for training/testing including status changes of employees (hired, terminated, resigned) within 30 days of the status change
iii. Utilize a standard form to obtain permission from current/prospective employees to access testing records in the online database: and
iv. In the event testing records are not available in the online database, a hard copy form must be used for testing record verification. A current/former/prospective employer of a DCW shall share upon request and/or may solicit testing records using the *Verification of Direct Care Worker Testing* form. The *Verification of Direct Care Worker Testing* form is available on the AHCCCS website www.azahcccs.gov/dcw. The employer shall maintain copies of the verification of testing forms provided to and/or requested from another DCW employer. Verification may also include an official transcript from an Approved Training and Testing Program of the test type(s), date(s), module(s), and score(s).

c. Back-up documentation shall be retained for a minimum period of six years. Back-up documentation includes the testing search authorization standard form and back-up documentation for any and all entered data in the online database or any data pertaining to training and testing of DCWs. The documentation can be retained in either an electronic or hard copy filing system.

D. SUPERVISORY VISITS APPLICABLE TO ALL DIRECT CARE SERVICES

Agencies are required to perform periodic supervisory visits to assess and document the DCW's competency in performing the assigned duties in a safe manner, as ordered and according to the training the DCW has received. Supervisory visits must be documented in the member's case file and cross-referenced in the DCW's personnel file. There are distinct timeframes for these visits, as well as instances when DCWs must be present and circumstances when they do not need to be present. Therefore, the primary documentation is maintained in the member's file with a cross-reference to the DCW's file. Supervisory visits apply when services are provided under the AWC option as well.

When the agency determines through supervisory visits or other oversight activities that services were not provided as authorized, the reasons for the non-provision of services must be documented by the provider in the member's case file and reported to the m Contractor. The Contractor must be notified if any potential fraud or abuse is suspected (e.g., timesheet fraud by DCW and/or member/ representative).

1. Supervisory visits requiring the DCW's presence.

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

2. Supervisory visits not requiring the DCW's presence.

   The following supervisory visits do **not** require the presence of the DCW at the time of the visit, although these visits may be combined with Item 1 above as determined applicable.

   NOTE: The timing of these supervisory visits for the first 90 days is based on the date of the initial service provision, and not the date of the initial service authorization. After the first 90th day visit, all other 90 day visits occur at least every 90 days from the previous visit.

   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.

      i. From the date of initial service provision and for the next 90 days, supervisory visits are required by the 5th day, 30th day, 60th day (is only required if issues are identified) and 90th days from the initial service provision date.
      ii. The 5th day visit shall not occur on the day of the initial service provision. The 30th, 60th and 90th day visits must occur within five days of their due date.
      iii. After the initial 90th day visit, all other visits occur at least every 90 days from the previous visit. This 90th day visit must not occur more than five days after its due date.
      iv. Home Health Agency visits are in accordance with 9 A.A.C. 10, Article 11.

SUPERVISORY VISIT TABLE: EXAMPLE	
PROVISION OF SERVICE DATE: 05/01/2010	
TYPE OF VISIT	OPTIMAL VISIT DATE
5 Day	05/06/2010
30 Day	05/31/2010
60 Day	06/30/2010 (only if needed)
90 Day	07/30/2010
2nd 90 Day	10/28/2010

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. The supervisory visit requirements are the same as "a" in this section except that the 5th day visit, depending on the nature of the care being performed, can be made by telephonic contact.

E. EDUCATION STANDARDS APPLICABLE TO ALL DIRECT CARE WORKERS (ATTENDANT CARE, PERSONAL CARE AND HOMEMAKER SERVICES)

AHCCCS has established and imposed minimum competency standards for DCWs to ensure consistency in the provision of and the quality of care for ALTCS members. All DCWs must hold current certification in CPR and first aid, and meet the required training and testingstandards outlined in this policy All DCWs, including those who are family members, must demonstrate skills, knowledge and ability to provide care as a paid caregiver to ALTCS members. The specific knowledge and skills that are required are dependent on the type of care that will be provided. The DCW competencies, created through the Arizona Direct Care Workforce Initiative, provide the basis for the required training and testing. A DCW, including those who are family members, may require additional training to meet the specific needs of an individual ALTCS member.

The "Principles of Caregiving" provide the basis for the competencies for training and testing. Although agencies are not required to utilize the *Principles of Caregiving* training manuals, the competencies included in the *Principles of Caregiving* training manuals must be included in any alternative curriculum. The required tests are based on these competencies. Links to this and other information is located at http://www.azahcccs.gov/dcw.

1. Oversight Requirements:

   a. AHCCCS Administration Oversight: AHCCCS will be responsible for the review and approval of applications for an Approved Training and Testing Program. AHCCCS may audit Approved Training and Testing Programs to ensure compliance with Policy. See ACOM, Policy 429, at http://www.azahcccs.gov/dcw.

   b. Contractor Oversight: The Contractors will audit Approved Training and Testing Programs to ensure compliance with Policy. See ACOM, Policy 429 at http://www.azahcccs.gov/dcw.

2. Training and Testing Period Standards

   a. A DCW with an initial hire date prior to 10/01/2012 is deemed to meet the training and testing requirements with the DCW agency(ies) they are currently employed. However, if the DCW becomes employed with another agency on or after 10/01/2012, they shall meet the training and testing requirements contained within this policy. All DCWs with an initial hire date on or after 10/01/2012 must meet the DCW training and testing requirements contained within this policy.

   b. DCW agencies have 90 calendar days from date of hire to train and test DCWs. It is permissible for DCWs to provide care during the 90 day training period. In the event the DCW's 90 day training period has expired prior to the DCW receiving training and passing the knowledge and skills tests, the DCW must stop providing care until the training and testing requirements are met.

   c. A DCW who has not worked as a DCW or has no work experiences similar to that performed by DCWs in the last two years will be required to demonstrate competency by passing both a knowledge and skills test prior to caring for ALTCS members.

3. Training and Testing Exemptions

   a. A DCW who is a Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per A.R.S. 32, Chapter 15 is exempt from the DCW training and testing requirements. This exemption allows the DCW agency the discretion to test and train their employees as determined necessary.

b. A family caregiver who is providing care to a family members only, is excempt from the Level II – Specialized modules training and testing requirements.

2. Levels of Training

Demonstration of skills, knowledge and ability is required at the following levels for the specified direct care workers. Skills, knowledge and ability are demonstrated by completion of the course and passing a knowledge test and skills test that is based on the "Principles of Caregiving" or equivalent and approved curriculum. As discussed above in this section, completion of a training course is recommended; however, demonstration of knowledge and skills by testing is mandatory. Unless exempt as per Section1240 A, the DCWs must achieve a score of 80% for each knowledge test and pass all (100%) of the skills test for any curriculum modules. A DCW agency may permit an employee to take a challenge test (taking a test without being trained), for both the Level I and Level II modules, if they have the education similar to what is required for DCWs or work experiences similar to that performed by the DCWs. The agency must verify and document the DCWs related educational and work experiences.

a. Level I – Introduction to and Fundamentals of Caregiving

Must be completed by all DCWs, including family caregivers, to provide direct care services to ALTCS members (except as noted in 1240 A). Applicable to all DCWs providing Attendant Care, Personal Care, and Homemaker services.

b. Level II – Specialized Modules (Aging and Physical Disabilities or Developmental Disabilities).

Must be successfully completed by all DCWs providing Attendant Care, Personal Care or Homemaker services (excluding family caregivers who provide care to family members only). Successfully completing Level II means at least one of the specialty modules must be completed and the DCW must pass the knowledge test and skills test. DCWs shall take the appropriate Level II modules training and tests that correlates to the population that they serve. If the DCW serves both the elderly and physical disabled population and the developmentally disabled population they will be required to take both Level II modules.

3. Continuing Education

   a. Six hours of continuing education are required annually. For DCWs hired prior to October 1, 2012, the yearly timeframe for continuing education is from October-September. For DCWs hired on or after October 1, 2012, the yearly timeframe for continuing education is the anniversary of their date-of-hire.

   b. The training completed in the first year to become a qualified DCW can be counted towards the required six hours of continuing education.

   c. CPR and first aid training cannot count toward the six hour requirement.

   d. Continuing Education shall include training on additional curriculum modules and relevant topics. It is not the intent of continuing education to repeat the same topics year after year.
      i. The "Principles of Caregiving, Alzheimer's Disease and Other Dementias" module developed by representatives of residential care, home and community based care, experts in the fields of communication, behavior, and activities is recommended for continuing education. The module comes complete with test.

   e. For family caregivers, the continuing education can be specific to the service recipient.

   f. Continuing education can be offered in many forms, including in-service, video/Digital Video Disk (DVD), written material, attendance at a class or conference, and so forth. Consideration should be given to allow family caregivers to complete the materials at home.

F. SERVICE SPECIFICATION APPLICABLE TO DIRECT CARE SERVICES

The service specifications related to each Direct Care service (Attendant Care service, Personal Care service, and Homemaker) are individually discussed in this section. See additional information and requirements related to these services when they are provided through the Self Directed Attendant Care or the Agency with Choice options in Chapter 1300 of this manual.

I. 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, and general supervision. 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

Other HCBS may be provided in conjunction with attendant care. However, within the same 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 as these services are generally considered a duplication of each other.

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 member's 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 the care of the member while in a "Contractor Out-of-Service Area" in lieu of a nursing facility stay for the member.

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

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

b. Personal care including bathing, skin care, oral hygiene, toileting, ambulation, grooming, dressing, nail care, feeding as necessary, use of assistive devices and caring for other physical needs. Care specifically excludes skilled tasks such as wound care and bowel care that can only be performed by a licensed registered nurse or delegated by a licensed registered nurse to a licensed practical nurse.

c. General supervision which includes:

   i. Monitoring of a member who cannot be safely left alone.
   ii. Assisting with self-administration of medications, (when the member is physically unable to administer his/her medications, the member may direct the caregiver in this task), and
   iii. Monitoring the member's medical condition and ability to perform the activities of daily living.

d. 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.

e. Assistance with skill development, training in activities of daily living, and

f. 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.

2. <u>Program management components applicable to the Agency which provides Attendant Care Services.</u>

   a. Provide any necessary specialized training or technical assistance in order for a selected Attendant to provide necessary services to the member.

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

3. <u>Attendant Care Provider (Caregiver) / Parent as paid Caregiver standards and requirements.</u>

   The following immediate relatives may not provide attendant care:

   a. Natural parent *

b. Adoptive parent *, and

c. Stepparent*

* Parents may provide attendant care services if the member is 18 years or older, or under limited circumstances, for members under the age of 18, when approved by the AHCCCS Administration. For both FFS and managed care members under the age of 18, the decision for payment of a parent must be made in coordination with the AHCCCS Administration.

4. Attendant Care Provider (Caregiver) / Spouse as paid Caregiver standards and requirements:

For purposes of this section, "extraordinary care" means care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the ALTCS member if the member did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the member and to avoid institutionalization.
A member may choose to have attendant care services provided by his/her spouse as a paid caregiver subject to the following conditions and limitations:

a. The member must reside in his/her own home, as defined in Chapter 100 of this Manual.

b. The Program Contractor or Tribal Contractor ensures that the member understands that he/she has the choice of a provider of attendant care other than the member's spouse.

c. Attendant care services must be described in the member's care plan prepared by the member's case manager.

d. The case manager must at least annually record in the member's care plan the member's choice to have attendant care provided by the member's spouse as a paid caregiver (refer to Chapter 1600, Exhibit 1620-12 regarding signature of the "Spouse Attendant Care Acknowledgement of Understanding Form").

e. Attendant care services provided by the spouse must meet the definition of extraordinary care as described in this section.

f. The spouse must be:

i. Employed by a provider Agency that subcontracts with the member's Contractor or
ii. If the member is developmentally disabled, the spouse must be either employed by a provider Agency that subcontracts with the member's Contactor or employed by a member under the Division of Developmental Disabilities' Independent Provider network member-directed option. or
iii. If the member is a Native American enrolled in FFS, the spouse must be employed by an AHCCCS registered provider Agency.

g. The spouse must meet the standard training requirements and other provider qualifications included in this policy with one exception in respect to spouses employed by a member under the Division of Developmental Disabilities' Independent Provider Network member-directed options. In this circumstance, members may elect whether or not to require the DCW to satisfy the minimum competency standards outlined in Section 5 of this policy.

h. For managed care, the spouse must be paid at a rate that does not exceed that which would otherwise be paid to a non-spouse caregiver providing a similar level of attendant care services. For FFS, the spouse must be paid at a rate that does not exceed the capped FFS payment for attendant care services.

i. The spouse providing attendant care services as a paid caregiver shall not be paid for more than 40 hours of services in a seven-day period.

j. For a member who elects to have his/her spouse provide attendant care services as a paid caregiver, attendant care or similar services (e.g. personal care and homemaker), in excess of the 40 hours cannot be paid to the spouse regardless of who employs the spouse. A spouse who provides attendant care services or alternatively, personal care and homemaker services, is prohibited from providing more than 40 hours per week of paid care to the spouse under any circumstances: A different caregiver would be required to provide any care to the ALTCS member authorized in excess of 40 hours per week.

k. When a member has been authorized attendant care services with a spouse as the paid caregiver, who can only provide a portion of those hours, it is allowable to authorize another agency or DCW under the Division of Developmental Disabilities' Independent Provider Network member-

directed option to provide the balance of the authorized hours not to exceed 40 total hours of attendant care.

l. By electing to have the member's spouse provide attendant care services as a paid caregiver, the member is not precluded from receiving any other medically necessary, cost effective home and community-based services.. Members are eligible for respite care services subject to applicable limitations as noted in the respite care services section of this chapter.

II. PERSONAL CARE

Description

AHCCCS covers personal care services for 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 when that environment is not medically contraindicated and when it is cost effective to do so.

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:

Within the same day, personal care services cannot be provided in conjunction with attendant care, home health aide services, adult day health care or group respite, without special justification from the member's case manager that is approved by the Managed Care Contractor or the AHCCCCS Administration for Fee-For-Service (FFS) members. There are no restrictions on other services provided in conjunction with personal care services on any given day.

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

a. 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).

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

c. 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.

III. 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 when that environment is not medically contraindicated and when it is cost effective to do so.

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 provided in conjunction with homemaker services on any given day.

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:

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

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

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

d. Shopping for items such as food, cleaning and laundry supplies and personal hygiene supplies for the member only.

e. 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

f. 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 issues.

1240-B ADULT DAY HEALTH CARE SERVICES

REVISION DATES: 10/01/13, 07/01/12, 10/01/07, 03/01/07, 09/01/06, 06/01/06, 03/01/06, 07/01/04, 10/01/01, 07/01/99

INITIAL EFFECTIVE DATE: 02/14/1996

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 included. 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. Assisted Living Facilities are required by licensure standards and by State regulation (R9-10-808) to provide residents with adequate recreation and socialization opportunities. Members residing in a behavioral health residential facilities 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.

1240-C COMMUNITY TRANSITION SERVICE

REVISION DATE: 10/01/13, 07/01/12

INITIAL
EFFECTIVE DATE: 02/1/2011

Description

AHCCCS covers the Community Transition Service (CTS) for ALTCS members. The Community Transition Service is a fund to assist ALTCS institutionalized members to reintegrate into the community by providing financial assistance to move from an ALTCS Long Term Care (LTC) institutional setting to their own home or apartment. Members moving from an ALTCS LTC institutional setting to an alternative residential setting such as assisted living facilities or group homes are not eligible for this service. This service is limited to a one time usage per five years per member.

Definitions

For purposes of this Policy the following definitions apply:

1. ALTCS LTC Institutional Setting - means any one of the following settings: behavioral health inpatient facility, institution for mental disease, inpatient residential treatment center (available to Title XIX members under 21 years of age), nursing facility, including religious non-medical health care institution, Intermediate Care Facility for persons with Intellectual Disabilities (ICF).

2. Community Transition Service Provider - means an AHCCCS registered provider that facilitates the purchase and delivery of pre-determined goods and services as authorized by the case manager. The provider must retain receipts of all purchases for a minimum of five years.

3. Contractor – means ALTCS Managed Care or ALTCS Tribal Contractor.

Amount, Duration and Scope

The Community Transition Service is provided on a one unit per service basis.

1. Requirements for the Community Transition Service include the following:

    a. The member has been in an ALTCS LTC institutional setting a minimum of 60 consecutive days regardless of ALTCS enrollment

b. The member is within 30 days of being discharged into the community, and

c. The LTC institutional setting discharge plan identifies needs and assistance for which the member has no other source or support to initiate reintegration. It is not intended to supplant items or supports otherwise provided by the Contractor or other community resources. The member's needs must be met in a timely manner and cannot be delayed in anticipation of receiving services from other sources, for example, even when coordinating with other community sources for the provision of this service.

2. Funds are:

a. Limited to a one time authorization (see exception letter b below) of up to $2,000 per five year period. The $2,000 includes all applicable administration fees. The five year timeframe is applicable regardless of changes in Managed Care Contractors or if the member transfers between fee-for-service and managed care. It is the responsibility of the transferring Contractor to notify the receiving Contractor regarding use of this service via the ALTCS Enrollment Transition Information (ETI) Form, Chapter 1600, Policy 1620, Exhibit 1620-9.

b. Available 30 days prior to the planned discharge date and remain available for 90 days from the date of discharge from an ATLCS LTC institutional setting. Exceptions to this timeframe for partially expended funds will be determined on a case by case basis. The Contractor should contact the AHCCCS Operations and Compliance Officer assigned to its plan for discussion and direction when an exception occurs. If the 120 day authorization period expires and there has been no expenditure of funds, the Contractor must terminate the authorization. The service may be reauthorized at a later date if all other requirements of this Policy are met.

c. Not dispersed directly to the member. The ALTCS case manager assists the member and significant others with prioritization of needs and authorizes the Community Transition Provider to facilitate the purchase of identified goods and services.

3. Components of the Community Transition Service include but are not limited to:

a. Security deposits that are required to obtain a lease on an apartment or home (refunded deposits are the property of the Contractor).

b. Essential furnishings, whether new or gently used as appropriate for items such as bed, bedding, towels, table, chairs, window coverings, eating utensils, food preparation items, small electrical appliances.

c. Moving expenses required to occupy home or apartment.

d. Set up fees or deposits for utility or service access (e.g. telephone, electricity, heating). (Refunded deposits are the property of the Contractor)

4. The Community Transition Service excludes the following:

a. Cash payments to members or significant others

b. Rent

c. Leisure/recreational devices (e.g. purchase of television or cable access, internet access, stereo)

d. Aesthetics/decorative items (e.g. picture frames and rugs)

e. Remodeling improvements to any home or apartment (home modifications may be considered under that service as described in section 1240 of this Chapter)

f. Grocery supplies (including but not limited to food, personal hygiene, cleaning products).

1240-D EMERGENCY ALERT SYSTEM

REVISION DATES: 07/01/12, 10/01/07, 03/01/07, 03/01/06, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

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. The member lives alone in the member's own home or would be 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, when combined with other HCB services, is cost effective.

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, 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.

1240-E HABILITATION SERVICES

REVISION DATES: 10/01/14, 06/01/14, 10/01/13, 03/01/13, 07/01/12, 10/01/07, 03/01/07, 03/01/06, 10/01/01

INITIAL EFFECTIVE DATE: 02/14/1996

Description

AHCCCS covers habilitation services for Arizona Long Term Care System (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 Home and Community Based (HCB) settings. The services the provision of training in independent living skills or special developmental skills, orientation and mobility training, sensory-motor development, supported employment and intensive behavioral intervention for individuals with a diagnosis of autism when specific criteria are satisfied. 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 provider agencies 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 or an HCB alternative residential setting. 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 Behavioral Health Residential Facility. A person who assists an elderly person or an individual with a disability with activities necessary to allow them to reside in their own home (including habilitation services) must be employed by a provider agency, or in the case of member-directed options (as outlined in Chapter 1300 of this policy), by ALTCS members in order to provide such services to ALTCS Members. The provider agency or ALTCS member, in the case of member-directed options, establishes terms of employment.

Other Home and Community Based Services (HCBS) may be provided in conjunction with habilitation. Habilitation providers may carry out activities designed by a therapist as part

of the daily routine. AHCCCS encourages the therapist to train primary caregivers (paid and unpaid) to carry out the therapy activities within the normal routine of the member.

1240-F HOME DELIVERED MEALS

REVISION DATES: 07/01/12, 10/01/07, 03/01/07, 03/01/06, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

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 have a food handling/food preparation operating permit issued by the 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 to the provider 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. 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 or the member's representative, 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 provider 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, or friend. 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 as authorized, 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.

1240-G HOME HEALTH SERVICES

REVISION DATES: 10/01/14, 10/01/13, 07/01/12, 10/01/07, 03/01/07, 03/01/06, 07/01/04, 10/01/01

INITIAL EFFECTIVE DATE: 02/14/1996

Description

AHCCCS covers medically necessary home health services for ALTCS members. Home health services include home health skilled nursing visits, private duty nursing, home health aide services, medically necessary supplies, and therapy services. Home health services must be provided by a Medicare certified Home Health Agency (HHA) licensed by the Arizona Department of Health Services (ADHS) except as otherwise specified in this Policy. Under limited circumstances as described below, home health services may be provided by either a state licensed Home Health Agency or by an Independent Registered Nurse (RN) when specific criteria are met. With the exception of Independent RNs who are permitted to provide home health services when registered as AHCCCS registered providers as described in this Policy, RNs, LPNs and CNAs who provide home health services to ALTCS members must be employed by a HHA which establishes the terms and conditions of employment. Home health services must be authorized by a Case Manager.

Amount, Duration, and Scope

A. HOME HEALTH AGENCY SERVICES

ALTCS members who reside in their own home or a Behavioral Health Residential Facility may 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 that include skilled nursing services with the facility.

Refer to Exhibit 1240-1 for a listing of medical supplies included in FFS home health nursing visits. Refer to Exhibit 1240-2 for a matrix of services that may be provided by a home health nurse.

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. Authorized Home Health Aide services for personal care and/or homemaker

services as a part of HHA services, must not be provided separately by a homemaker/personal care or attendant care provider on the same day.

HHA services for ALTCS members must be provided by a Medicare certified HHA licensed by ADHS except in the circumstances delineated below. In these limited circumstances, services may be provided by a non-Medicare certified/State licensed HHA or by an Independent RN. All other requirements of 42 CFR 440.70 apply, however, skilled nursing services must be provided by an RN.

A non-Medicare certified/State licensed HHA or an Independent RN is permitted to provide home health services only under the following circumstances:

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

2. The Medicare certified HHA in the applicable geographic area lacks adequate staff to provide the necessary services for 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 for home health services as specified above, the following apply:

1. <u>Non –Medicare/State Licensed Home Health Agency</u>

    a. The Contractor must contract with a state licensed HHA.

    b. The Contractor must maintain documentation supporting at least one of the three circumstances specified above.

    c. The state licensed HHA must be an AHCCCS registered provider which employs the individuals providing home health services.

    d. Skilled nursing services must be provided by an RN who is employed by the state licensed HHA.

2. <u>Independent RN</u>

    a. The Contractor must maintain documentation supporting at least one of the three circumstances specified above**.**

    b. Independent RNs must submit, in writing, a minimum of three references from persons who are not family members to the Managed Care Contractor,

or, for services to FFS members, to the AHCCCS Administration. All references must be contacted and the results documented in the employee's personnel record prior to approving the provision of home health services from the Independent RN.

c. The Independent RN must be registered as an AHCCCS registered provider.

d. The Independent RN must have completed an orientation to clinical and administrative recordkeeping provided by a nurse approved by, or contracted with, a Managed Care Contractor prior to providing skilled home health nursing.

e. Independent RNs 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.

f. Managed Care Contractors who contract with Independent RNs to provide home health skilled nursing must develop oversight activities to monitor service delivery and quality of care provided by the Independent RN.

g. For FFS members, the attending physician must monitor the Independent RN.

B. 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 L, of this Manual for case management quarterly consultation and documentation requirements.

5. A unit of home health intermittent nursing is 15 minutes. The length of a single visit should not exceed two hours (8 units). No more than four hours (16 units) may be provided per day. Examples include:

VISITS PER DAY	UNITS PER VISIT
1	4 units
2	1st visit / 8 units; 2nd visit / 8 units
3	1st visit / 8 units; 2nd visit / 4 units; 3rd visit / 4 units

C. 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 (more than two hours in duration) as an alternative to hospitalization or institutionalization when care cannot be safely managed within the timeframe 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 C.F.R. 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 is responsible for all documentation of member care. Contractors who contract with 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 for the independent private duty nurse.

The unit of private duty nursing service is one hour for visits of more than two hours in duration.

D. 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 they exhibit medical or social problems during the course of service delivery.

E. HOME HEALTH THERAPY SERVICES

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

1240-H RESERVED

"Homemaker Services" is now located in Policy 1240-A.

1240-I HOME MODIFICATIONS

REVISION DATES: 07/01/12, 10/01/07, 03/01/07, 03/01/06, 01/01/05, 04/01/04, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

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.

It 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 occupational 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 to AHCCCS Administration/Division of Fee for Service Management. Refer to Exhibit 1240-4 for a copy of the required form.

3. Under 42 C.F.R. 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, Care Management Systems Unit (CMSU), and prior authorized by the Manager of the CMSU 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.

6. Examples of modifications 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 his or her 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.

7. 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 60 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.

1240-J RESERVED

"Personal Care" is now located in 1240-A.

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, nonsterile 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

PROVIDER TYPE	HOME HEALTH NURSE (INTERMITTENT) (BILLED IN 15 MINUTE UNITS FOR VISITS OF TWO HOURS OR LESS IN DURATION, UP TO A TOTAL OF FOUR HOURS PER DAY)		PRIVATE DUTY NURSE (CONTINUOUS) (BILLED IN HOURLY UNITS FOR VISITS OF MORE THAN TWO HOURS IN DURATION OR SERVICES EXCEEDING FOUR HOURS IN A SINGLE DAY)	
	RN HCPCS CODE	LPN HCPCS CODE	RN HCPCS CODE	LPN HCPCS CODE
Medicare Certified Home Health Agency	**G0154**	**G0154**	**S9123**	**S9124**
State Certified Home Health Agency	**G0154**	**Not Covered**	**S9123**	**S9124**
Independent Nurse	**G0154**	**Not Covered**	**S9123**	**S9124**

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

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

EXHIBIT 1240-3
AHCCCS/ALTCS FFS HOME MODIFICATION REQUEST/JUSTIFICATION FORM

SECTION A. TO BE COMPLETED BY REQUESTOR. ATTACH ALL REQUIRED DOCUMENTATION.				
Fax completed form to: AHCCCS-DFSM-PA Unit Fax: (602) 254-2426 **Send:** Service Assessment Uniform Assessment Tool (UAT)		**Tribal Contractor**		
		Case Manager		
		Address		
		Phone/Fax		
		Signature/Date		

1. MEMBER'S NAME _____ DOB _____ AHCCCS ID# _____

2. MEMBER'S ADDRESS _____ _____
City/Zip Code *Phone # or Alternative Phone #*

3. PCP'S INFORMATION _____ _____ _____
PCP Name *Phone #* *Fax #*

Diagnosis & Code (Related to need)

4. MEMBER RESIDES IN (check one): HOME Own? Or Rent? OTHER (specify)

5. CURRENT ADL STATUS ☐ Independent ☐ Mod Assist ☐ Dependent
Bladder/Bowel Status ☐ Continent ☐ Mod Incontinent ☐ Total Incontinent
Mental Status ☐ Alert ☐ Confused

6. CURRENT MOBILITY STATUS ☐ Independent ☐ Walker/Cane ☐ Wheelchair

7. DESCRIBE MODIFICATION(S) BEING REQUESTED (USE SEPARATE SHEET OF PAPER IF NEEDED):

MODIFICATION REQUESTED	JUSTIFICATION	APPROVED	DENIED
Ramp with Handrails			
Walk-in Shower			
Roll-in Shower			
Grab Bars – Shower or Toilet (Circle)			
Widen Doors- Bathroom, Bedroom, Front (Circle)			
Lever Handles-Bathroom, Bedroom, Front Door (Circle)			
High Rise Toilet or Roll Under Sink (Circle)			
Special Request- Please Explain			

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

SECTION B. TO BE COMPLETED BY AHCCCS			
BUILDING CONTRACTOR/PROVIDER NAME	LICENSE #	PROVIDER ID	COST
			$

COMMENTS: _____

APPROVED _____ SIGNATURE _____ DATE _____
(NAME AND TITLE)

DENIED _____ SIGNATURE _____ DATE _____
(AHCCCS MEDICAL DIRECTOR OR DESIGNEE)

REVIEW DATE: 07/01/2012 REVISION DATE: 07/01/2010(R), 11/2009, 3/2006, 4/2004

1250 SERVICES PROVIDED IN BOTH HCBS AND INSTITUTIONAL SETTINGS

1250-A BEHAVIORAL HEALTH SERVICES

REVISION DATES: 07/01/12, 03/01/06, 09/01/04, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

Description

AHCCCS covers behavioral health services 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 of this Chapter, 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 of this Manual, for a listing of covered services and the Behavioral Health Services Guide for a complete description of the services.

1250-B HOSPICE SERVICES

REVISION DATES: 07/01/12, 10/01/07, 03/01/06, 09/01/05, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

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 members or caregivers in order to ease 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 when the conditions of participation are met as specified in 42 C.F.R. 418:

1. Hospital
2. Nursing care institution, and
3. Free standing hospice.

Providers of hospice care must be Medicare certified and licensed by the Arizona Department of Health Services (ADHS) and have a signed AHCCCS provider agreement.

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 however shall report such cases to 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 300 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 300 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 availability to provide services such as reassurance, information and referral for members and their families or caretakers.

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 member care, the volunteer must meet qualifications required to provide such services.

14. Medical supplies, appliances and equipment, including pharmaceuticals, which are used in relation 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.

1250-C MEDICAL/ACUTE CARE SERVICES

REVISION DATES: 10/01/14, 07/01/12, 10/01/07, 03/01/06, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

Description

Medical/acute care services and service limitations are covered as specified in Chapter 300, Policy 310 of this Manual. 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. Note that there are limitations to specific acute care services for adult members, ages 21 and over.

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 1250-1 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.

1250-D RESPITE CARE

REVISION DATES: 03/15/15, 10/01/14, 07/01/12, 10/01/11, 07/01/11, 07/01/10, 10/01/07, 03/01/06, 10/01/01

INITIAL EFFECTIVE DATE: 02/14/1996

Description

AHCCCS covers respite care as a short term service for ALTCS members residing in their own home. Services are provided as an interval of rest and/or relief to a family member or other persons caring for the ALTCS member.

Amount, Duration and Scope

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

When respite care is provided for a period of less than 12 hours regardless of the date during which the respite began, the respite care is authorized according to the number of units provided. The unit of service for respite care less than 12 hours is 15 minutes. When respite care is provided for 12 – 24 continuous hours regardless of the date during which the respite began, the respite care is authorized at a per diem rate. The combined total of short-term and/or continuous respite care cannot exceed 600 hours per benefit year. The benefit year is defined as a one year time period of October 1st through September 30th. The 600 hours are 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. 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 are 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).

A person who assists an elderly person or an individual with a disability with activities necessary to allow them to reside in their own home (including respite services) must be employed by a provider agency in order to provide respite services to ALTCS Members. The provider agency establishes terms of employment.

At a minimum, individuals who provide respite care 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.

If respite care is provided in an institutional setting or an 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 members with skilled nursing needs living in their own home, or an HCB approved alternative residential setting, it must be provided at the member's level of medical need. Respite care may be provided by private duty skilled nursing services, if available and determined to be medically necessary and cost effective.

If skilled nursing personnel are unavailable to provide respite care to members with respiratory care needs (such as ventilator dependent members), services may be provided by a respiratory therapist when both of the following conditions are met:

1. The member's primary care provider 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 or the member.

1250-E REHABILITATIVE THERAPIES

REVISION DATES: 07/01/12, 10/01/10, 02/01/10, 10/01/07, 03/01/06, 10/01/04, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

Description

AHCCCS covers occupational, physical, respiratory and speech therapy services, that are ordered by a Primary Care Provider (PCP), approved by the Managed Care Contractor or the AHCCCS Division of Fee-for-Service Management for FFS members 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, an HCB approved alternative residential setting or an institutional 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.

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/attending physician of the member's restoration potential, there must be an expectation that the condition will improve significantly in a 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 of this Manual for additional information regarding therapy services.

A. PHYSICAL THERAPY

Description

AHCCCS covers inpatient and outpatient 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. Refer to Chapter 300, Policy 310-X of this Manual for information related to settings and visit limitations and provider qualifications.

B. OCCUPATIONAL THERAPY

Description

AHCCCS covers inpatient and outpatient 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, or the aging process. The services include activities such as evaluation, treatment and consultation. Refer to Chapter 300 of this Manual for information related to provider qualifications.

C. SPEECH THERAPY

AHCCCS covers inpatient and outpatient ST services including 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. Services, that do not require a qualified speech-language pathologist, such as practicing word drills, are not covered services. Refer to Chapter 300 of this Manual for information related to provider qualifications.

D. 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. Refer to Chapter 300 of this Manual for information related to provider qualifications.

1250-F MEDICAL SUPPLIES, EQUIPMENT, APPLIANCES AND CUSTOMIZED DURABLE MEDICAL EQUIPMENT

REVISION DATES: 07/01/12, 10/01/07, 03/01/07, 03/03/06, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

Description

Medical supplies, equipment, appliances and customized Durable Medical Equipment (DME) are covered as specified in Chapter 300, Policy 310 of this Manual, 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 of this Manual for the definition of customized DME.

Refer to Chapter 400, Policy 430 of this Manual, for criteria related to coverage of incontinence briefs for members over 3 years old and under the age of 21.

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

1250-G NUTRITIONAL ASSESSMENTS AND NUTRITIONAL THERAPY

REVISION DATES: 10/01/15, 07/01/12, 10/01/07, 03/01/07, 03/01/06, 10/01/01

INITIAL EFFECTIVE DATE: 02/14/1996

Description

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

1. Chapter 400, Policy 430, *EPSDT Services* – Provides language and requirements specific to nutritional assessments and nutritional therapy for all members 20 years of age and under (Acute and ALTCS members).

2. Chapter 300, Policy 310-GG, *Nutritional Assessment and Nutritional Therapy* – Provides language and requirements specific to nutritional assessments and nutritional therapy for all members 21 years of age or greater (Acute and ALTCS members).

3. Chapter 300, Policy 320-H, *Metabolic Medical Foods* – Provides language and requirements specific to members with specific metabolic diseases.

1250-H TRANSPORTATION

REVISION DATES: 07/01/12, 10/01/07, 03/01/07, 03/01/06, 10/01/01

INITIAL
EFFECTIVE DATE: 02/14/1996

In addition to the transportation services described in Chapter 300, Policy 310 of this Manual, ALTCS also covers the cost of companion services for members who need escort care to and from medical appointments. The service may be provided when a member is unable to be transported to medical appointments alone, such as when a member needs physical assistance during an appointment that a medical practitioner is unable to provide or there is a risk that a member could wander away from an appointment without supervision.

Companion services may be provided to members residing in their own home, an 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 of the member's needs. A companion 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 1250-1

AUTHORIZATION OF ALTCS SERVICES

EXHIBIT 1250-1
AUTHORIZATION OF ALTCS 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 (AHCCCS) 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]
Community Transition Service			X	X	X
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	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, Standard H "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 Integrated RBHAs/RBHAs.

Revision Dates: March 2014, July 2012, February 2011, March 2006, November 2004, October 2001, June 2000

EXHIBIT 1250-2

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

EXHIBIT 1250-2
AHCCCS/ALTCS
SERVICES, SERVICE CODES AND APPLICABLE UNITS OF SERVICE

SERVICE TYPE	CODE	UNIT INCREMENTS
INSTITUTIONAL SERVICES		
INTERMEDIATE CARE FACILITY **NOTE: DD MEMBERS ONLY**	0190	Per diem
NURSING FACILITY – LEVEL I	0191	Per diem
NURSING FACILITY – LEVEL II	0192	Per diem
NURSING FACILITY – LEVEL III	0193	Per diem
NURSING FACILITY – LEVEL IV	0194	Per diem
NURSING FACILITY – RESPITE	0199	Per diem. Limited to 25 days per benefit year
BED HOLD – THERAPEUTIC LEAVE	0183	Per diem. Limited to 9 days per benefit year
BED HOLD – HOSPITAL ADMISSION	0185	Per diem. Limited to 12 days per benefit year
ALTERNATIVE RESIDENTIAL SETTINGS NOTE: Modifiers may be used to distinguish levels of care. **TF** modifier means intermediate level of care. **TG** modifier means complex/high level of care.		
ASSISTED LIVING HOME	T2031	Per diem
ASSISTED LIVING CENTER	T2033	Per diem
ADULT FOSTER CARE	S5140	Per diem
HABILITATION – RESIDENTIAL **(USED FOR DD GROUP HOME)**	T2016	Per diem
BEHAVIORAL HEALTH RESIDENTIAL FACILITY **NOTE:** Behavioral Health Residential may be appropriate for stays of any length. The code is the same.	H0018	Per diem
BEHAVIORAL HEALTH THERAPEUTIC HOME • Home Care Training to Home Care Client (Child) • Home Care Training to Home Care Client (Adult) • Home Care Training to Home Care Client (Adult Geriatric)	S5109 HA S5109 HB S5109 HC	Per diem Per diem Per diem
HOSPICE SERVICES		
ROUTINE HOME CARE	0651	Per diem
CONTINUOUS HOME CARE	0652	Per diem
INPATIENT RESPITE CARE	0655	Per diem
GENERAL INPATIENT CARE	0656	Per diem
SERVICE TYPE	**CODE**	**UNIT INCREMENTS**
HOME AND COMMUNITY BASED SERVICES		
ADULT DAY HEALTH CARE	S5100 S5101 S5102	15 Minutes (up to 11 units) Half Day (12 – 23 units) Per Diem (24+ units)

EXHIBIT 1250-2
AHCCCS/ALTCS
SERVICES, SERVICE CODES AND APPLICABLE UNITS OF SERVICE

SERVICE TYPE	CODE	UNIT INCREMENTS
HOME AND COMMUNITY BASED SERVICES **Continued**		
ATTENDANT CARE For purposes of modifier U4 or U5, family member means: • Adult children/Step children of member • Son/Daughter-in-law of member • Grandchildren of the member • Siblings /Step Siblings of member • Parents /Step Parents of members • 18 years (per Federal policy, parents of members < 18 cannot be paid caregivers) • Grandparents • Mother/Father-in-law • Brother/Sister-in-law	S5125 S5125 / U3 S5125 / U4 S5125 / U5 S5125 / U2 S5125 / U6 S5125 / U7	15 Minutes Provided by spouse, limited to maximum of 40 hours/week Provided by family member, non-spouse, not residing in member's home Provided by family member, non-spouse, residing in member's home Self-Directed Attendant Care (SDAC) SDAC – skilled services Agency With Choice (AWC)
COMPANION CARE	S5135 S5136	15 Minutes Per Diem
COMMUNITY TRANSITION SERVICE	T2038	1 Unit per episode (once per 5 years)
EMERGENCY ALERT SYSTEM	S5160/NU 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/NURSING	G0154 S9123 S9124	Home Health Nurse (Intermittent) Home Health Nurse (Continuous) – Registered Nurse Home Health Nurse (Continuous) – Licensed Practical Nurse
HOME HEALTH SERVICES/HOME HEALTH AIDE	T1021	1 Unit per Visit
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

NOTE: Refer to Exhibit 1240-2 for more information regarding home health skilled nursing/private duty nursing services.

Revision Date: July 2012, February 2011, December 2009, October 2007
Initial Date: March, 2006

1260 RESERVED

1270 RESERVED