

Chapter 1200	Services and Settings
1200	Overview
1210	Institutional Services and Settings
1220-C	Pre-Admission Screening and Resident Review
1230-A	Assisted Living Centers
1230-C	Room and Board
1240-A	Attendant Care and Homemaker
1240-C	Community Transition Services
1240-D	Emergency Alert System
1240-E	Habilitation Services
1240-G	Home Nursing
1240-H	Home Health Aide
1240-I	Home Modifications
1250-B	Hospice
1250-C	Medical and Acute Care Services
1250-D	Respite
1250-E	Therapies (Rehabilitative and Habilitative)
1250-F	Medical Supplies, Equipment, Appliances, and Customized Durable Medical Equipment
1250-G	Nutritional Assessments and Nutritional Therapy
1250-H	Transportation
1280	State Funded Services
Exhibit 1240A-1	Attendant Care Supervision Requirements Age 17 and Under
Exhibit 1240A-2	Attendant Care Supervision Requirements Age 18 and Above
Exhibit 1240A-3	Attendant Care Supervision Documentation Requirements
Exhibit 1240G-1	Skilled Nursing Matrix

1200 OVERVIEW

REVISION DATE: 6/10/2016, 7/3/2015

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REFERENCES: A.R.S. §§ 36, 32-1, 36-2939(B)(1), 36-591(G); A.A.C. R6-6-901 - R6-6-910; C.F.R. §§ 42, and, 42-456.1.

The following section contains information about services available either through the Arizona Long Term Care System (ALTCS) or the State only funded programs administered by the Division. Each eligible member will receive services in accordance with documented needs and availability of State funds.

The Arizona Long Term Care System (ALTCS) provides funding for certain services based upon assessed needs and medical necessity. ALTCS does not provide day care or educational services. Transitional Waiver services include all Home and Community Based Services under ALTCS and supported employment. The Transitional Waiver is a program for members who were eligible for the Arizona Long Term Care System and have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) level of care. The Transitional Waiver does not cover institutional services in excess of 90 days.

Based on assessed need, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) drives what services, types and amounts of support a member may receive. The person with a disability may request the Planning Team to help them identify what their needs are, the best ways to meet those needs and what the primary caregiver(s) is willing and able to do. Often a person's services needs may be met through natural supports (such as relatives, friends, places of worship and local community resources). A contracted service provider may also be used. Though funding for services through ALTCS is not intended to replace what families currently provide, under certain circumstances parents or family members may be paid to provide services that support home and community living.

Although the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan planning documents processes identifies needed services, members who are eligible for ALTCS shall receive information regarding their right to receive services as authorized.

Members who are eligible for ALTCS shall also receive information regarding the appropriate Division staff to contact if services are not provided as scheduled. The Support Coordinator must assess with the member their needs, the risk to the member if a gap in services were to occur and develop a contingency plan in the event of a services gap. These needs and risk factors are determined at the time of the initial and quarterly (90 day review) assessments. The Support Coordinator shall also explain the guidelines regarding the Divisions process (including a time estimate) for providing services when there is a service gap. The Division tracks and trends these gaps in services per the Arizona Health Care Cost Containment Systems (AHCCCS) contract requirements. The Division also submits a semi-annual report and other necessary reports to the AHCCCS summarizing trends, services gaps, and related grievances.

Primary care givers are not required to be in the home during the delivery of services unless one of the following situations exists:

- A. The primary care giver provides "skilled care" and the service being provided is non-skilled care. In this case, the primary care giver would need to perform any "skilled care" that the provider is not certified/licensed to do.
- B. The intent of the service as documented on the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) is to facilitate the primary care giver's ability to work with the member. As an example, the service is intended to directly train the family in learning how to respond to behavior problems.

Each person must be evaluated on a member basis to determine medical necessity as well as the cost effective level of care that will achieve the desired results. Only nurses or respiratory therapists can provide skilled care. For example, skilled care includes Jejunum tube insertion, catheter replacement, respiratory treatment such as small volume nebulizers suctioning, tracheostomy care.

Guidelines for services and evaluation criteria are found in the Service Approval Matrix (Prior Authorization). This information is available on the Division's website.
<https://www.azdes.gov/main.aspx?menu=96&id=2470>

The source information regarding each service is found in one of the following documents:

- A. Chapter 42 Code of Federal Regulations. www.gpo.gov;
- B. AHCCCS Medical Policy Manual. www.azahcccs.gov;
- C. A.R.S. §36. www.azleg.gov/ArizonaRevisedStatutes.asp; or,
- D. The Division Service Specifications.

1210 INSTITUTIONAL SERVICES AND SETTINGS

REVISION DATE: 8/15/2017, 7/15/2016, 5/13/2016, 2/12/2016, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: A.R.S. §§ 36-2939(A)(1), (B)(1), 36-591(G); A.A.C. R9-10-101, 42 CFR 409.31-35, 438.6(e), 440.40, 440.155, 456.1, 456.436, 483.75, 483.100-138, 483.400, 483.440; Division Medical Policy Manual, Policy 1220-C Pre-Admission Screening and Resident Review; Division Operations Policy Manual, Policy 2001 Planning Team Members

The Division of Developmental Disabilities (Division) covers medically necessary institutional services provided in an Arizona Health Care Cost Containment System (AHCCCS) registered long term care facility for members who are eligible for the Arizona Long Term Care System (ALTCS).

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. The Division uses an acuity tool to determine the level of institutional placement prior to placement.

Members who are eligible for the ALTCS transitional program are not eligible for Nursing Facility (NF) services or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services exceeding 90 continuous days per admission.

Nursing Facility

Service Description and Goals (Nursing Facility)

This service provides skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care or direct daily care from a physician.

The goal of this service is to provide care that meets and enhances the medical, physical, and emotional needs of members residing in Nursing Facilities (NF).

Service Settings (Nursing Facility)

NFs must be Medicare and Medicaid certified and licensed by the Arizona Department of Health Services in accordance with 42 CFR 440.155 and 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis. For the purposes of reimbursement by ALTCS funding, the facility must be Medicare/Medicaid certified.

Service/Provider Requirements (Nursing Facility)

The provider must demonstrate the following before the service is authorized:

- A. The NF must be licensed and certified by the appropriate Arizona state agencies.

- B. The NF must comply with all applicable federal and state laws relating to professional conditions, standards, and NF requirements, including the conditions set forth in the 42 CFR 483 *et seq.*
- C. The NF must also comply with all health, safety, and physical plant requirements established by federal and state laws.
- D. The portion of the facility in which the member will be placed must be registered with AHCCCS.

Admission Criteria (Nursing Facility)

- A. The NF service may be considered appropriate for a member if the member is in need of skilled nursing care on a 24-hour basis but does not require hospital care or direct daily care from a physician and is ordered by, and provided under, the direction of a physician, pursuant to 42 CFR 440.40.
- B. Pursuant to 42 CFR 409.31-35 and 440.155, the member requires:
 - 1. The skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists
 - 2. Daily skilled services that can only be provided in an NF, on an inpatient basis
 - 3. Skilled services because of special medical complications
 - 4. Services that are above the level of room and board.
- C. The member must cooperate in a nursing assessment performed by the Division District Utilization Review Nurse prior to NF service being authorized.
- D. The Pre-Admission Screening and Resident Review (PASRR) is completed pursuant to 42 CFR 483.100-138 (see Division Medical Policy Manual, Policy 1220-C Pre-Admission Screening and Resident Review).
- E. Prior to the authorization, the above criteria in this section must be met.

Exclusions (Nursing Facility)

- A. The Division will authorize an NF placement only in a licensed and Medicare/Medicaid certified NF.
- B. The Division will not pay for placement in an NF without prior authorization pursuant to 42 C.F.R 483.100 *et seq.* (see Division Medical Policy 1220-C Pre-Admission Screening and Resident Review).
- C. If the Primary Care Provider (PCP) or the Division District Utilization Review Nurse advises that the NF cannot meet the member's needs, the member shall be offered a choice of available alternatives, including less restrictive settings and/or Home and Community Based Services (HCBS), as medically necessary.

- D. If the Division places an NF on termination status:
 - 1. No new members will be admitted to the NF.
 - 2. Members currently residing, or on leave from, the NF may remain or return to the facility and will have a special planning meeting scheduled. The planning meeting must identify contracted residential alternatives that are available to the member.
- E. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.
- F. The member is in the Transitional Program and requests Long Term Care placement.

Therapeutic Leave and Bed Holds (Nursing Facility)

If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the NF.

- A. Therapeutic leave includes leave due to a therapeutic home visit to enhance psychosocial interactions, a trial basis, or as a part of discharge planning, and is limited to 9 days per calendar year.
- B. A bed hold includes medically necessary short-term hospitalization and is limited to 12 days per calendar year.

Reassessment for Continued Placement (Nursing Facility)

- A. Members residing in an NF must be reassessed by the Division for appropriateness (medical necessity) of placement, whenever a significant change in the physical or mental status of the member occurs (see PASARR section of this policy manual).
- B. Physicians must order the continued need for NF placement not less than annually in accordance with 42 CFR 483.114.
- C. The member must continue to meet the criteria in the Admission Criteria (Nursing Facility) section of this Policy.

Service Closure (Nursing Facility)

As determined by the PASRR, medical documentation, and the current needs of the member, NF services will be terminated when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met. The discharge shall occur as follows:

- A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to update the current Planning Document to include:
 - 1. The member's health and abilities
 - 2. Current medication
 - 3. Identification of needed Durable Medical Equipment (DME)

4. An updated Service Plan
 5. A completed Cost Effectiveness Study (CES) based on anticipated service needs
 6. Needed follow up medical appointments.
- B. The Planning Team includes the member and/or responsible person, the Division's Health Care Service (HCS) nurse, the Support Coordinator, and representatives from the NF. The Planning Team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division's Operations Manual, Policy 2001 Planning Team Members.
- C. In the event the member's previous living arrangement needs to change, the Support Coordinator makes a request for residential services by completing a Placement Profile and submitting it to the Division's District Network Unit.
- D. The member or responsible person, the PCP, attending Physician, and the Division's Medical Director shall resolve disagreements regarding discharge planning.
- E. The Division's Chief Medical Officer has the final authority as delegated by the Assistant Director.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Service Description (ICF/IID)

ICF/IID provides comprehensive and individualized health care, and habilitative and rehabilitative services, to members to promote functional status and independence for members who need, and are receiving, active treatment services that help the member obtain as much independence as possible.

Service Settings (ICF/IID)

An ICF/IID shall include the Arizona Training Program facilities, a state-owned and operated service center, state-owned or operated community residential settings, and private state-certified facilities that contract with the Department.

Service Provider/Facility Requirements (ICF/IID)

The provider must be state operated or contracted with the Division and demonstrate the following before the service is authorized:

- A. The ICF/IID is registered with the Arizona Health Care Cost Containment System (AHCCCS).
- B. The ICF/IID must be reviewed and certified annually by the Department of Health Services in accordance with 42 CFR 483.400.
- C. The ICF/IID must comply with contract, all applicable federal and state laws, and DES and Division policies and procedures.

Admission Criteria (ICF/IID)

- A. The ICF/IID service may be considered appropriate for a member who is in need of, or could benefit from, active treatment.
1. Active treatment includes continuous, aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that are directed toward:
 - a. The acquisition of the behaviors necessary for the member to function with as much self-determination as possible and the ability to live in a more independent setting
 - b. The prevention or deceleration of regression or loss of current optimal functional status.
 2. Active treatment is provided continuously based on an individual member's assessed developmental needs that prevent the member from living in a more independent setting.
 3. A continuous active treatment program includes interaction, between ICF/IID staff and the member, in which the member receives aggressive and consistent training, treatments, and supports during the normal rhythm of the member's day, whenever the need arises or an opportunity presents itself, in both formal and informal settings.
 4. Examples of active treatment may include:
 - a. The application of a specific stimulation technique, to the area of the mouth of an individual with severe physical and medical disabilities, that decelerates the individual's rate of reliance on tube feedings, and helps the individual retain ability to take food by mouth
 - b. Teaching the member to use an adaptive spoon and plate to eat independently
 - c. Acquisitions of behaviors for the member to function with as much self-determination and independence as possible
 - d. Teaching daily living skills.
 5. Examples of what active treatment does not include:
 - a. Services to maintain generally independent members who are able to function with little supervision or in the absence of an active treatment program

- b. Protective oversight for a member who is not in need of training for developmental deficits (e.g., a court placement to protect the community or the client from the client's behavior)

Programs to simply maintain a member's independence are not considered active treatment because the member is not learning to live in a more independent setting. If a member already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support, resources, and services that only an ICF/IID can provide, the member is considered generally independent and not in need of active treatment.

- B. Prior to any permanent or temporary admission, the Division will complete a preliminary evaluation. The preliminary evaluation will consider background information as well as currently valid assessments of functional development, behavioral, social, health, and nutritional status and assessed needs that are prohibiting the member from living in a more independent setting and which require intensive specialized supports, services, and supervision that only an ICF/IID can provide.

The Division will review all necessary medical or other documentation to support the need for admission into an ICF/IID. This information may include the Planning Document, Placement Profile and, if the member receives nursing or therapies, the Nursing Assessment and Therapy evaluations/reports. If any additional information (e.g., medical records) is required, the Division's HCS will contact the Support Coordinator.

- C. The Division will determine whether there are alternative placements that are less restrictive and more cost effective than the requested ICF/IID placement. The alternative options shall be discussed with the member and/or their responsible person before a final decision is made by the Division.
- D. A Cost Effectiveness Study must be completed prior to admission.
- E. A written ICF/IID placement approval from the Assistant Director or the Assistant Director's Designee is required prior to authorization.

Development and Implementation of the Active Treatment Plan (ICF/IID)

- A. Pursuant to 42 CFR 483.440, within 30 days after admission:
 - 1. A comprehensive functional assessment of the member is completed.
 - 2. As a result of the comprehensive functional assessment, specific objectives necessary to meet the member's needs will be identified.
 - 3. A written active treatment program specific to the member will be designed and implemented.
- B. Data documentation of the specific objectives must be in measurable terms.

- C. The initial active treatment plan must be reviewed by a Qualified Intellectual Disability Professional/Support Coordinator, the Planning Team, and revised as necessary.
- D. During the annual planning meeting the comprehensive functional assessment shall be reviewed for relevancy and updated as needed.

Exclusions (ICF/IID)

ICF/IID placements shall not be made when any of the following are true:

- A. The member's needs can be met in a less restrictive and more cost-effective HCBS option.
- B. The member does not need active treatment in an ICF/IID.
- C. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.
- D. The member is in the Transitional Program and requests Long Term Care placement.

Therapeutic Leave and Bed Holds (ICF/IID)

If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the ICF/IID.

- A. Therapeutic Leave includes leave due to a therapeutic home visit to enhance psychosocial interactions or on a trial basis or as a part of discharge planning and is limited to 9 days per calendar year.
- B. A bed hold includes when short-term hospitalization is medically necessary and is limited to 12 days per calendar year.

Continued Stay Reviews (ICF/IID)

- A. The Division completes "Continued Stay Reviews" pursuant to 42 CFR 456.436 and "Active Treatment Reviews."
- B. The "Continued Stay Reviews" and "Active Treatment Reviews" will be completed at least every six months, and the following will be considered:
 - 1. The member no longer needs, and will not benefit from, continued active treatment in an ICF/IID.
 - 2. The member requires protective oversight only.
 - 3. The member is able to function with little supervision in the absence of an active treatment program.
 - 4. A less restrictive and more cost effective level of service or living situation would meet the needs of the member as determined by the Planning Team.

Service Closure (ICF/IID)

ICF/IID services may be terminated:

- A. As determined by the Continued Stay Review
- B. As necessary for the member's welfare and when the needs of the member cannot be met in the ICF/IID
- C. When the member has met their outcomes and no longer needs the services provided by the ICF/IID
- D. At the request of the member/responsible person
- E. When the member is no longer eligible for ALTCS
- F. When the criteria in the Admission Criteria (ICF/IID) section in this Policy are no longer met
- G. When the ICF/IID is no longer operating and a less restrictive or more cost effective level of service or living situation can meet the needs of the member.

The discharge shall occur as follows:

- A. Ten days prior to anticipated discharge, a team meeting must occur to update the member's current Planning Document to include:
 - 1. The member's health and abilities
 - 2. Current medication
 - 3. Identification of needed Durable Medical Equipment (DME)
 - 4. An updated Service Plan
 - 5. A completed Cost Effectiveness Study based on anticipated service needs
 - 6. Needed follow up medical appointments.
- B. The Planning Team shall include the member or responsible person, the Division's HCS nurse, the Support Coordinator, and representatives from the ICF/IID. The team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division's Operations Manual, Policy 2001 Planning Team Members.
- C. In the event the member's living arrangement needs to change from what it was previously, the Support Coordinator makes the request for residential services by completing a Placement Profile and submitting it to the Division's District Network Unit.

- D. The member or responsible person, the PCP, attending Physician and the Division's Chief Medical Officer shall resolve disagreements regarding discharge planning and service closure.
- E. The Division's Chief Medical Director shall have the final authority as delegated by the Assistant Director.

Behavioral Health

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities.

Behavioral Health Inpatient Facility

A Behavioral Health Inpatient Facility is a behavioral health service facility licensed by ADHS, as defined in A.A.C. R9-10-101, 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 Behavioral Health Inpatient Facilities are IMDs.

Institution for Mental Disease (IMD)

Services provided to members eligible for Title XIX (including members who receive behavioral health services through an Integrated/Tribal/Regional Behavioral Health Authority (IRBHA, RBHA, TRBHA) may be reimbursed in any behavioral health setting, regardless of age, as per AHCCCS Medical Policy Manual, Policy 1210.

An IMD is 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.

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

An Inpatient Psychiatric Residential Treatment Center is a behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A member who turns age 21 and is Tribal ALTCS Title XIX 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.

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:

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

- B. Medical/acute care services as specified in this Policy Manual.

1220-C PRE-ADMISSION SCREENING AND RESIDENT REVIEW

REVISION DATE: 4/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: CFR 42-483.100-483.138, 42-483.112(c), 42-483.112 (c-2), 42-483.12 (a) 1-7, 42-431 (E), and, 42- 447.

Federal nursing home reform legislation enacted through the 1987 Omnibus Reconciliation Act (OBRA) established the Pre-Admission Screening and Resident Review (PASRR) Program. The PASRR regulations mandate that all members entering a Title XIX (Medicaid) certified nursing facility be screened for a cognitive/intellectual disability or a related diagnosis and/or mental illness to avoid inappropriate placement. In addition, the OBRA specifies that placement for members with a cognitive/intellectual disability or mental illness are made based on their needs for nursing facility services and for specialized services.

State Medicaid agencies are required to develop a two-stage identification and evaluation process, which accomplishes the following:

- A. *PASRR Level I* – Identification of potential cognitive/intellectual disability or mental illness - Determines whether the member has any diagnosis or other presenting evidence that suggests the potential of a cognitive/intellectual disability or mental illness.
- B. *PASRR Level II (Determination)* – Determines whether the member does indeed have a cognitive/intellectual disability or mental illness. If the member has been determined to have a cognitive/intellectual disability or mental illness, this stage of the evaluation process determines whether the member requires the level of services provided by a nursing facility and/or specialized services.

Service Description

The procedures described in this section will apply to all members seeking admission of a 30-day or longer stay in a Title XIX or Medicaid certified nursing facility.

State Agreement Requirements

Referrals for a PASRR Level II determination of cognitive/intellectual disability are handled by the Arizona Department of Economic Security (DES) through the Division of Developmental Disabilities (DDD). Interagency agreements between the Arizona Health Care Cost Containment System (AHCCCS) Administration and the Division have been established to develop and maintain the Level II process to determine whether each member referred by primary care providers, nursing facilities or the AHCCCS/Arizona Long Term Care System (ALTCS) Administration (Pre-Admission Screening Assessors) requires the level of services provided by a nursing facility and/or specialized services for a cognitive/intellectual disability.

Cognitive/intellectual disability

Developmental disability is defined as a chronic disability which is attributable to a cognitive/intellectual disability, cerebral palsy, epilepsy, autism, and any related condition. The disability results in the impairment of general intellectual functioning or adaptive behavior and requires medical treatment or services. The impairment must be manifested before the age of 22. The impairment must be likely to continue indefinitely and result in substantial functional limitations in major life activities. When determined by a medical professional the range of intellectual functioning (mild, moderate, severe, or profound) will be documented on the PASRR Level II Evaluation.

Specialized Services (as pertaining to cognitive/intellectual disability)

The services specified by the cognitive/intellectual disability authority which, when combined with services provided by the nursing facility or other service providers, result in treatment which includes aggressive, consistent implementation of a program of specialized, and/or generic services, and related services that are directed toward the following:

- A. The acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible; and
- B. The prevention or deceleration of regression or loss of current optimal functional status.

If there are indications of a cognitive/intellectual disability or a related diagnosis, the completed PASRR Level I and all supporting documentation should be forwarded to the Division. Supporting documentation may include the Minimum Data Set (MDS), health and progress notes, assessments, or other documentation by a medical professional that suggests the presence of a cognitive/intellectual disability. Specialized services include aggressive, consistent implementation of a program of specialized and/or generic services, and related services that are directed toward the acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible, and the prevention or declaration of regression or loss of current optimal functional status.

The PASRR Level I is reviewed by the PASRR Coordinator who then determines if a Level II is necessary. If so:

- A. The PASRR Coordinator will contact the facility and speak to the referring member to confirm the current placement and that the medical files for the resident will be reviewed.
- B. The MDS in the member's file will also be reviewed for information concerning the member's functioning level and medical problems. The information gathered from the MDS and the member's resident's medical files will assist in completing the Level II. PASRR Level II determinations must be completed within an average of seven to nine working days of receipt of referral.

IF THE MEMBER IS AWAITING DISCHARGE FROM A HOSPITAL, THE LEVEL II WILL BE COMPLETED AS SOON AS POSSIBLE, AND IF NECESSARY BEFORE THE FEDERALLY MANDATED SEVEN TO NINE WORKING DAYS TIMEFRAME.

Pre-Admission Screening And Resident Review Determination

The PASRR Level II evaluation instrument and necessary procedures developed by the Division gather pertinent information needed to determine and recommend appropriate levels of care and services and when applicable in the least restrictive environment that could continue to provide the needed medical treatment. The criteria used in making a decision about appropriate placement will not be affected by the availability of placement alternatives.

Evaluation Requirements

PASRR reviews will be adapted to the member's cultural background, language, ethnic origin, and means of communication. Current and relevant assessment information obtained prior to the initiation of the PASRR process may be used. Findings must be accurate and correspond to the members' current functional level and must be descriptive.

The Division may convey the determinations verbally to the referring agency and the member and then confirm them in writing in accordance with 42 CFR 483.112 (c-2).

Copies of the completed PASRR Level II are forwarded to the referring agency, facility, AHCCCS and if dually diagnosed (cognitive/intellectual disability and mental illness) to Arizona Department of Health Services, the primary care physician and the member and/or representative, with a notice of the member's right to appeal the determinations.

The Division is responsible for ensuring that appropriate level of care and medical services are provided to those members who have been diagnosed prior to their 22nd birthday to have a cognitive/intellectual disability or a related diagnosis.

The Division's PASRR Coordinator is responsible for interpretation of the PASRR findings to the person or designated family member and/or representative if the applicant for admission or resident is incapable of understanding the PASRR findings.

ANNUAL REVIEWS ARE NOW REVISED REVIEWS AND WILL BE CONDUCTED WHEN: A significant change has occurred in the member's physical or mental condition. It is a federal requirement for a nursing facility to notify the state authority promptly when and if a significant change has occurred utilizing the Minimum Data Sets (MDS) guidelines for significant change requirements to ensure that all members with a cognitive/intellectual disability or related diagnosis continue to require nursing facility services and or specialized services. The Division's PASRR Coordinator also will search the data base every month and contact the facility to inquire if any significant changes have occurred to warrant a revised PASRR Level II. If no change has occurred, a letter is sent to confirm the conversation and is placed in the resident's file. If a significant change has occurred, pertinent information is gathered again, and the resident is scheduled for a Revised Review.

A REVISED PASRR LEVEL II IS NOT NEEDED FOR RE-ADMISSIONS FROM THE HOSPITAL OR INTER-FACILITY TRANSFERS.

Cease Process and Documentation Situation

If, at any time during this process it is found that the member does not have a cognitive/intellectual disability or related diagnosis or has a principal/primary diagnosis of Dementia, Alzheimer's Disease, or any related disorder or has any condition identified in section B of the PASRR Level I, that situation will be documented and the process will be stopped. If the illness results in a level of impairment so severe the member could not be expected to benefit from specialized services the process will be stopped.

THE DIVISION WILL RE-ASSESS THE MEMBER WHEN NOTIFIED BY THE NURSING FACILITY OF AN IMPROVEMENT IN HIS/HER CONDITION.

Nursing Facility Level of Care Inappropriate

The nursing facility in accordance with the state authority must provide or arrange for the safe and orderly discharge of the resident in accordance with 42 CFR 483.12 (a) 1-7, the member shall be prepared and oriented for discharge.

Any members who are currently enrolled with the Division of Developmental Disabilities Division who have been found to be unsuitable for a Skilled Nursing Facility should be informed of less restrictive placement options and when in agreement, discharged to a less restrictive setting. Their Support Coordinator must ensure that the Member Support Plan process is followed, including participation by the member or responsible representative, primary care physician, nursing facility staff, District discharge planning team and other relevant members.

Appeal Mechanism

The Division will ensure that the person or their designee is informed of the appeals process available to them: appeal of determination for members who are adversely affected (members for whom the screening process indicated that admission to nursing facility would not be appropriate) the appeals process must follow the guidelines contained in 42 CFR 431 Subpart E. The Division will also recommend appropriate placement alternatives.

Referral Designation

The Division will maintain case records for all Level II evaluations for a period of five years in accordance with 42 CFR parts 447.

1230-A ASSISTED LIVING FACILITIES

REVISION DATE: 7/15/2016, 7/3/2015

EFFECTIVE DATE: June 30, 1994

Description

“Assisted Living Center” (Center) means an assisted living facility that provides resident rooms or residential units to eleven or more residents. Assisted Living Centers may be licensed to provide one of three levels of care listed below, as defined by the Arizona Department of Health Services:

- A. “Supervisory Care Services” means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in the self-administration of prescribed medications.
- B. “Direct Care Services” means programs and services, including personal care services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.
- C. “Personal Care Services” means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medication and treatments by a nurse who is licensed pursuant to Arizona Revised Statutes Title 32, Chapter 15 or as otherwise provided by law.

“Assisted Living Home” (Home) means a facility that provides resident rooms and services to ten or fewer residents.

Considerations

To ensure the appropriateness of a placement in a facility, the following must be considered and documented:

- A. The member is over the age of 60; however, the team can recommend exceptions for approval by the Assistant Director;
- B. A nursing home is the only other alternative available or the team feels a facility best meets the needs, desires, and capabilities of the member;
- C. Alternate placements were considered and the reason why they were not appropriate. Facility placement cannot be the only placement option considered and cannot be used as an “emergency” placement alternative;
- D. The member and/or guardian clearly understand the alternative placement options;
- E. The guardian, member, and the Support Coordinator have visited the proposed facility;

- F. The member will be placed with a similar age group as the other members living in the facility and not be segregated based on disability;
- G. The supports identified in the Individual Support Plan/Person Centered Plan can be provided by the Center;
- H. The member must be given the choice to live by with or without a roommate. The Support Coordinator shall document this choice on the Assisted Living Facility/Single Occupancy Form. This form shall be filed with the Planning Document and be reviewed annually. At any time the member may contact their Support Coordinator to revise their choice to live with or without a roommate. When this occurs the Support Coordinator shall update the form;
- I. The Support Coordinator and others can monitor the facility at any time. Monitoring by the Support Coordinator, through on-site visits, will be conducted at least every 30 days for the first quarter and every 90 days thereafter; and,
- J. The District Program Manager/designee has reviewed the required documentation and concurs the considerations has been met prior to the authorization of services.

Conditions

When identifying potential facilities, the following conditions are recommended:

- A. Private room (unless the member chooses to have a roommate as noted above);
- B. Room includes a private in-room bathroom (unless the member chooses to have a roommate as noted above);
- C. Space allows for separation of sleeping and living areas;
- D. An inside door lock;
- E. Food preparation space;
- F. Doorbell or door knocker;
- G. Individual mailbox;
- H. Variety of on-site and off-site and events from which to choose;
- I. Transportation;
- J. Indoor and outdoor common areas;
- K. Weekly housekeeping service;
- L. Weekly laundry service; and,

M. Monthly newsletter or calendar of events.

Exclusions

- A. Under no circumstance will a facility be used for Respite.
- B. The Division provides Adult Developmental Homes in lieu of Adult Foster Care Homes.
- C. The Division does not contract with Adult Foster Care Facilities

1230-C ROOM AND BOARD

REVISION DATE: 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

Service Description and Goals (Room and Board)

This service provides for a safe and healthy living environment on a 24-hour basis that meets the physical and emotional needs of a member.

Service Settings (Room and Board)

Room and board may be provided in any state operated or contracted community residential setting.

Service Requirements (Room and Board)

Before Room and Board can be authorized, the following requirements must be met:

- A. Living arrangements for members served must be identified; and,
- B. Nutritional maintenance for members served must be ensured and provided.

Target Population (Room and Board)

All members receiving services in a residential setting may also receive room and board.

Exclusions (Room and Board)

Exclusions to the provision of Room and Board include Home and Community Based Services. Other room and board services excluded are those funded by Arizona Long Term Care System (ALTCS). All other fund sources shall be exhausted prior to funding by the Division.

Service Provision Guidelines (Room and Board)

RESERVED

Provider Types and Requirements (Room and Board)

Designated District staff will ensure all contractual requirements are met before Room and Board is provided.

Service Evaluation (Room and Board)

The provider shall maintain an on-site file that documents appropriate inspections and licenses necessary to operate the home.

Service Closure (Room and Board)

This service shall be terminated when a member moves from a State operated or contracted residential setting.

1240-A ATTENDANT CARE AND HOMEMAKER (DIRECT CARE SERVICES)

REVISION DATE: 2/26/2016, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

Attendant Care

Description

This service provides assistance for a member to remain in their home and participate in community activities by attaining or maintaining personal cleanliness, activities of daily living, and safe and sanitary living conditions.

Barring exclusions noted in this section, Attendant Care (ATC) may include the following as determined by the member's assessed needs:

- A. Meal preparation and clean up (e.g., meal planning, preparing foods, special diets, clean-up, and storing foods);
- B. Eating and assistance with eating;
- C. Bathing (e.g., washing, drying, transferring, adjusting water, and setting up equipment);
- D. Dressing and grooming (e.g., selecting clothes, taking off and putting on clothes, fastening braces and splints, oral hygiene, nail care, shaving, and hairstyling);
- E. Toileting (e.g., reminders, taking off and putting on clothes and/or undergarments, cleaning of catheter or ostomy bag);
- F. Mobility (e.g., physical guidance or assisting with the use of wheelchair);
- G. Transferring;
- H. Cleaning;
- I. Laundry (e.g., putting clothes in washer or dryer, folding clothes, putting away clothes);
- J. Shopping (e.g., grocery shopping and picking up medications);
- K. Attending to certified service animal needs; and,
- L. General supervision for a member who cannot be safely left alone. (See Appendix A, B and C.)

Responsible Person's Participation (Attendant Care)

The member/family is responsible to provide:

- A. Needed supplies (e.g., cleaning supplies) or money for supplies. Money must be provided in advance when the Attendant Care provider is expected to shop for food, household supplies, or medications; and,
- B. Documentation required for the approval of this service.

Considerations (Attendant Care)

When assessing the need for this service, the following factors will be considered:

- A. Due to advancing age, a temporary or permanent documented physical or cognitive/intellectual disability or documentation of other limitation, the parent or guardian cannot meet a child's basic care needs;
- B. Due to the child's intensive medical, physical, or behavioral challenges, which are a result of the disability, the parent or guardian cannot meet the child's care needs;
- C. The child, due to a medical condition or procedure related to the disability, is unable to attend their school/work/day program, and natural support(s) is/are unavailable to provide care;
- D. The adult member is unable to meet specific, basic personal care needs;
- E. The adult member lives alone and is temporarily unable to meet basic personal care needs due to a medical condition or illness;
- F. The members' needs are not currently met due to unavailability of service. Attendant Care may be used as an alternative service;
- G. The member has medical or physical needs, was living in a Developmental Home, Group Home, Intermediate Care Facility, Nursing Facility, or other out of home placement, and with Attendant Care, the member will be able to return home;
- H. When a spouse provides Attendant Care, the total hours of Attendant Care may not exceed 40, regardless of who provides the care. In addition, the member may not receive any similar or like service (i.e., Homemaker). (Habilitation services are not a similar or like service.);
- I. Attendant Care services are subject to monitoring and supervision as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy; and,
- J. When a family member requests to become the Attendant Care Provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

Settings (Attendant Care)

Attendant Care Services may only be provided:

- A. In the member's home (unlicensed);
- B. In an Independent Developmental Home when there is a specific issue, problem, or concern that is believed to be temporary or short term, and the service is approved by the Assistant Director/designee; and,
- C. In the community:
 - 1. While accompanying the member; or,
 - 2. While shopping or picking up medications.

Exclusions (Attendant Care)

Exclusions to the authorization of Attendant Care service are indicated below. Exceptions shall be approved by the District Manager.

- A. The Attendant Care Service:
 - 1. Shall not substitute for private pay day care or a school program for children;
 - 2. Shall not cover before and after school care needs, days when there is no school, half school days, holidays, or summer and winter breaks, or for 'babysitting' unless a child meets the criteria for supervision;
 - 3. Shall not be provided for acute illnesses that prevent the child from attending private daycare or school;
 - 4. Shall not be provided while the member is hospitalized;
 - 5. Shall not substitute for Work, Day Program, Transportation, or Habilitation, unless those services are not available to the member;
 - a. When used as a substitute, Attendant Care shall be used only until an appropriate service is available; or,
 - b. When the appropriate service has been refused, Attendant Care cannot be used as a substitute.
 - 6. Shall not substitute for Respite;
 - 7. Shall not be received during the provision of a Division funded Employment or Day Program;
 - 8. Shall not be used to avoid residential licensing requirements;
and,
 - 9. Shall not be used to take the place of care provided by the natural support system for children.
- B. The tasks below are not included as part of the Attendant Care Service:

1. Cleaning up after parties (e.g., family celebrations and holidays);
2. Cleaning up several days of accumulated dishes;
3. Preparing meals for family members;
4. Routine lawn care;
5. Extensive carpet cleaning;
6. Caring for household pets;
7. Cleaning areas of the home not used by the member (e.g., parents' bedroom or sibling's bathroom);
8. Skilled medical tasks. (See Appendix D – Skilled Nursing Matrix.); and,
9. Shopping for a child living in the family home.

The Division will not authorize Attendant Care when the only tasks identified are cleaning, shopping and laundry.

Homemaker (Housekeeping)

Service Description and Goals (Homemaker)

This service provides assistance in the performance of activities related to routine household maintenance at a member's residence. The goal of this service is to increase or maintain a safe, sanitary, and/or healthy environment for eligible members.

Service Settings (Homemaker)

This service would occur in the member's own home or family's home. It would occur outside only when unsafe/unsanitary conditions exist and would occur in the community when purchasing supplies or medicines.

Service Requirements (Homemaker)

Before Homemaker can be authorized, the following requirements must be met:

- A. Safe and sanitary living conditions shall be maintained only for the member's personal space or common areas of the home the member shares/uses.
- B. Tasks may include:
 1. Dusting;
 2. Cleaning floors;
 3. Cleaning bathrooms;

4. Cleaning windows (if necessary to attain safe or sanitary living conditions);
 5. Cleaning oven and refrigerator (if necessary to prepare food safely);
 6. Cleaning kitchen;
 7. Washing dishes;
 8. Changing linens and making beds; and,
 9. Routine maintenance of household appliances.
- A. Washing, drying, and folding the member's laundry (ironing only if the member's clothes cannot be worn otherwise).
- B. Shopping for and storing household supplies and medicines.
- C. Unusual circumstances may require the following tasks be performed:
1. Tasks performed to attain safe living conditions:
 - a. Heavy cleaning such as washing walls or ceilings; and,
 - b. Yard work such as cleaning the yard and hauling away debris.
 2. Assist the member in obtaining and/or caring for basic material needs for water heating and food by:
 - a. Hauling water for household use;
 - b. Gathering and hauling firewood for household heating or cooking including sawing logs and chopping wood into usable sizes; and,
 - c. Caring for livestock used for consumption including feeding, watering and milking.
 3. Provide or ensure nutritional maintenance for the member by planning, shopping, storing, and cooking foods for nutritious meals.

Target Population (Homemaker)

Members who are eligible for or are receiving assistance through the Supplemental Payment Program (SPP) will not receive Housekeeping. Members who are not eligible for Arizona Long Term Care Services (ALTCs) should be referred to the SPP. Needs are assessed by the Support Coordinator based upon what is normally expected to be provided by a member and/or his/her caregiver. It is important to remember that housekeeping services are based on "assessed need" and not on a person's or the family's stated desires regarding specific services.

Consideration should be made to age appropriate expectations of the member and his/her entire family (what can reasonably be expected of each member based on his/her age). The team should consider the natural supports available and not supplant them. In addition

to the guidelines found in this section, there may be a need for the SPP if any of the following are factors:

- A. A member is living with his/her family and has intense medical, physical, or behavioral needs; and the family members are unable to care for the member and maintain a safe and sanitary environment;
- B. A member is living with his/her family and the family members have their own medical/physical needs that prevent the family members from maintaining a safe and sanitary environment (documentation of the medical/physical needs may be required);
- C. A member is living independently and has medical/physical needs that preclude him/her from maintaining/attaining a safe and sanitary environment;
- D. A member is living independently and has demonstrated that he/she cannot maintain a safe and sanitary environment. Habilitation should be considered before using Housekeeping so the member's abilities may be maximized; and,
- E. The family is experiencing a crisis that prevents them from maintaining a safe and sanitary environment. The situation would be documented in the member's progress notes and the service delivery would be of a time-limited nature.

Exclusions (Homemaker)

The following exclusions apply to the provision of Homemaker:

- A. Homemaker is to be performed only for the members' areas of the home or common areas of the home used by the member, e.g., parents' or siblings' bedrooms or bathrooms would not be cleaned. Other examples of inappropriate use of Homemaker services include:
 - 1. Cleaning up after parties;
 - 2. Cleaning up several days of accumulated dishes;
 - 3. Preparing meals for the whole family; and,
 - 4. Routine lawn care.
- B. Homemaker shall not be provided to members residing in group homes, vendor supported developmental homes, skilled nursing facilities, non-state operated Intermediate Care Facilities for Persons with an Intellectual Disability or Level I or Level II Behavioral Health Facilities.

Service Provision Guidelines (Homemaker)

Typical utilization of Homemaker would be two to four hours per week. Additionally:

- A. The member or family is expected to provide all necessary supplies;
- B. This service shall not be provided when the member is hospitalized or otherwise receiving institutional services. The service may only be provided at the end of hospitalization to allow the member to return to a safe and sanitary environment; and,
- C. Members residing in Group Homes, Foster Homes or Adult Developmental Homes shall not receive this service.

Utilization of Homemaker will be in accordance with the Service Authorization Matrix.

Provider Types and Requirements (Homemaker)

Designated District staff will ensure all contractual requirements related to Homemaker providers are met before services can be provided. Additionally, all providers of ALTCS must be certified by the Division and registered with AHCCCS prior to service initiation.

Service Evaluation (Homemaker)

The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan review (Plan Review) shall document appropriateness of this service based upon the Support Coordinator's observation and input from the member, family, and provider.

Service Closure (Homemaker)

This service is no longer appropriate when:

- A. The member's medical, physical or behavioral needs have decreased;
 - B. The physical/medical needs of the family members have decreased;
 - C. The family is no longer experiencing crisis;
 - D. The member no longer resides at home, has moved out of state, or when the member is no longer eligible for ALTCS;
 - E. The member moves to a residential or institutional setting; or,
 - F. The family has adequate resources or other support to provide the service.
- A Notice of Intended Action must be sent in accordance with the processes defined in of this policy manual.

Other Homemaker Services

- A. The amount of Homemaker provided shall be determined based on the home requirements for a safe and sanitary environment. If more than one eligible member resides in the home, payment will not be made twice for cleaning common areas of the home.

- B. If the family is receiving supplemental payments for other members in the home, the Support Coordinator shall determine if the Supplemental Payment Program (SPP) is meeting the family's needs.

1240-C COMMUNITY TRANSITION SERVICES

REVISION DATE: 3/2/2015

EFFECTIVE DATE: June 30, 1994

Description

The Community Transition Service (CTS) assists members eligible for Arizona Long Term Care System (ALTCS) to reintegrate into the community by providing financial assistance to move from an ALTCS setting to their own home or apartment, excluding licensed community settings.

An ALTCS setting includes one of the following:

- A. Behavioral Health Level I facility;
- B. Institution for Mental Disease;
- C. Inpatient Psychiatric Residential Treatment Center (available to members under 21 years of age eligible for Title XIX.);
- D. Nursing Facility, including religious non-medical health care institution; and,
- E. Intermediate Care Facility (ICF).

The following items can be purchased using CTS funds:

- A. Security deposits required to obtain a lease on an apartment or home (refunded deposits are the property of the Division);
- B. Essential furnishings (new or gently used including items such as: bed, bedding, towels, table, chairs, window coverings, eating utensils, food preparation items, small electrical appliances);
- C. Moving expenses; and,
- D. Set up fees or deposits for utility or service access (e.g., telephone, electricity, gas). (Refunded deposits are the property of the Division.)

Considerations

The following factors will be considered when assessing the need for this service:

- A. The member has been living in an ALTCS 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 setting discharge plan identifies needs and assistance for which the member has no other source or support to move.

1. It is not intended to replace items or supports otherwise provided by the Division or community resources.
2. The members' needs shall be met upon discharge and discharge cannot be delayed in anticipation of receiving services from other sources (e.g., when coordinating with other community sources for the provision of this service).

Exclusions

Community Transition Services are:

- A. Not available to members moving from an ALTCS setting to an alternate residential setting such as Assisted Living Facilities, Group, or Developmental Homes;
- B. Limited to a one-time authorization (see exception letter C below) of up to \$2,000 every five years per member;
 1. The \$2,000 includes all applicable administration fees.
 2. The five year timeframe applies regardless of changes in Managed Care Contractors or the member transfers between fee-for-service and managed care.
- C. Available 30 days prior to the planned discharge date and remain available for 90 days from the date of discharge from an ALTCS institutional setting. Exceptions to this timeframe for partially expended funds will be determined on a case-by-case basis.
- D. Not dispersed to the member, the member's family, or friends.
 1. Funds are paid directly to the vendor identified by the member or family.
 2. Receipts for all purchases using CTS funds shall be retained for a minimum of five years.
 3. The Support Coordinator will assist the member and family with prioritization of needs and facilitate the purchase of identified goods and services.

The following items cannot be purchased using CTS funds:

- A. Cash payments to members or significant others;
- B. Rent;
- C. Leisure/recreational devices (e.g., television or cable access, internet access, stereo);
- D. Aesthetics/decorative items (e.g., picture frames, rugs);
- E. Remodeling improvements to any home or apartment; and,

F. Grocery items (e.g., food, personal hygiene, cleaning products).

1240-D EMERGENCY ALERT SYSTEM

REVISION DATE: 3/2/2015

EFFECTIVE DATE: June 30, 1994

Description

An Emergency Alert System is a monitoring device/system for members who are unable to access assistance in an emergency situation.

Barring exclusions noted in this section, Emergency Alert System may include:

- A. One emergency alert system unless a second is medically necessary;
- B. The medically necessary accessories for operation;
- C. Voice or touch capability; or,
- D. Replacement of equipment in cases of loss, irreparable damage, or wear not caused by carelessness or abuse.

Considerations

The following factors will be considered when assessing the need for this service:

- A. The member lives alone or is alone for eight or more hours without contact with a service provider, family member, or other support system and cannot call 911 by using a standard phone, portable phone, or cell phone;
- B. The member's community does not have reliable/available emergency assistance on a 24-hour basis;
- C. The assessment of the member's medical and/or functional level documents an acute or chronic medical condition, which is not improving; and,
- D. The primary care provider has prescribed the system.

Settings

An Emergency Alert System may only be provided in the member's own or family home.

Exclusions

An Emergency Alert System shall not be provided:

- A. To members living in Group Homes or Child/Adult Developmental Homes; and,
- B. When the member no longer meets the target population/service considerations (e.g., the member moves to a Group Home or the member is no longer alone for

eight hours or more). When this occurs, the system and all components must be returned to the Division.

1240-E HABILITATION SERVICES

REVISION DATE: 9/15/2017, 7/15/2016, 7/3/2015, 3/2/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: A.A.C. R6-6-903

Habilitation Consultation

A. Service Description and Goals (Habilitation Consultation)

This service assists a member to remain in his/her home or the family/caregiver's home and to participate in community activities, by providing a variety of behavioral interventions. Habilitation Consultation is a consultative service that is intended to complete an assessment and develop an intervention plan. The plan identifies strategies to strengthen the skills of the member and his/her family/caregivers. The member must be eligible for ALTCS and the family/caregivers must have the ability and interest to participate in this service.

Habilitation Consultation may include:

1. Conducting an assessment of the member's challenging behavior and/or area of skill deficit
2. Developing an intervention plan derived from the assessment for the family/caregivers, and/or direct care workers to implement with the member to improve the member's self-help, socialization, and adaptive skills
3. Assisting Planning Teams and family/caregivers, and/or direct care workers in managing the member's challenging behaviors through a thorough understanding of the purpose and function of a behavior and how that behavior has been reinforced in the past
4. Facilitating implementation of the intervention plan and strategies
5. Modeling the implementation of the intervention plan for the member, family/caregivers, and/or direct care workers, including the teaching of functional alternative or replacement behavior (behavior that serves the same function for that member)
6. Training the family/caregivers, and/or direct care workers in the implementation of the intervention plan and monitoring their fidelity in the use of the treatment interventions as outlined in the intervention plan
7. Assisting the Planning Team in acquiring any needed approvals of the intervention plan by oversight committees, as required per A.A.C. R6-6-903
8. Providing follow-up consultation to revise the intervention plan as needed.

B. Family/Caregivers and Direct Care Workers (Consultation)

This service requires participation in training, provided by the habilitation consultation provider, on the specific activities and techniques developed in the intervention plan. Training participants may include family/caregivers and direct care workers, based on where the member lives. The Planning Team identifies all participants to receive the training and documents this in the member's record.

C. Referral Considerations (Habilitation Consultation)

The Planning Team determines the need for a referral for Habilitation Consultation when:

1. There is a deficit in functional living or adaptive skills including, but not limited to social communication skills, daily living skills, and independent living skills, AND
2. One or more of the following considerations apply:
 - a. Frequent visits (two or more in the last 6 months) to an emergency department for non-health emergency conditions
 - b. Multiple admissions (two or more in the last 6 months) to psychiatric acute care and/or psychiatric facilities
 - c. Multiple contacts (two or more in the last 30 days, or an escalation in frequency) with crisis services
 - d. Contact with law enforcement related to behavior (one or more in the last 30 days)
 - e. Multiple incident reports related to behavior (i.e., physical aggression, self-harm) showing a trend or escalation in the last 30 days
 - f. Multiple physical restraints (two or more in the last 30 days)
 - g. Behavior outbursts placing any of the following settings at risk:
 - i. Family/own home
 - ii. Out of home placement
 - iii. Day program
 - iv. School
 - v. Employment
 - vi. Any community setting

- h. Behavioral health, home and community based services have been unsuccessful in addressing the needs of the member and/or family to date and behavior intervention planning and assistance is needed to stabilize the behavior and the environment
- i. A consistently and correctly used Behavior Plan has not been successful in addressing the needs of the member.

D. Settings (Habilitation Consultation)

- 1. This service may be provided in any of the following settings:
 - a. The member's own home or family home
 - b. A Group Home
 - c. A state-supported or a vendor-supported Developmental Home (child or adult)
 - d. A community setting chosen by the member and his/her Planning Team
 - e. An Intermediate Care Facility
 - f. A Skilled Nursing Facility.
- 2. This service may be provided for observation and assessment purposes only in the member's school, during school provided transportation to and from school, and the hospital.

E. Exclusions (Habilitation Consultation)

- 1. This service cannot be provided when a member is receiving:
 - a. Habilitation, Early Childhood Autism Specialized service
 - b. Positive Behavioral Support-Consultation service
 - c. Positive Behavioral Support service
 - d. Comprehensive or focused behavior intervention services from any other funding source
 - e. Or residing in a facility identified as an Institute for Mental Disease (IMD).
- 2. Training on, and implementation of, the specific activities developed in the intervention plan are not to be provided:
 - a. In the school setting
 - b. During school provided transportation

c. When the member is hospitalized.

F. Service Authorizations (Habilitation Consultation)

Initial service authorizations cover a six month timeframe and include the following:

1. A maximum of 10 units of Habilitation Consultation Evaluation (billing code HCA) to complete the initial assessment and intervention plan.
2. A maximum of 110 units of Habilitation Consultation, Licensed Psychologist /Behavioral Analyst/BCBA (billing code HCM)/ Habilitation Consultation, Assistant (billing code HCB) for training, modeling implementation, and consultation. Leftover units of HCA may be authorized as HCM/HCB at the request of the Habilitation Consultation provider.

Prior to the end of the six-month authorization period, all progress reports will be reviewed to determine the member's progress and the continued need for the service. If the service is determined to be medically necessary, based on the review of the data and documentation, a service extension will be authorized for an additional six month period.

No additional hours of HCM/HCB will be authorized in the extension period until the initial authorized units have been exhausted.

Day Treatment and Training

A. Service Description and Goals (Day Treatment and Training)

This service provides specialized sensory-motor, cognitive, communicative, behavioral training, supervision, and as appropriate, counseling, to promote skill development in independent living, self-care, communication and social relationships.

The goals of this service are to:

1. Increase or maintain the self-sufficiency of eligible members.
2. Improve emotional and mental well-being.
3. Enable eligible members to acquire knowledge and skills.
4. Ensure the availability to eligible members of information about, and access to, human services and community resources.
5. Develop positive relationships with, and support for, families.
6. Encourage family and member participation in areas of the program.
7. Ensure that programs optimize the health and physical well-being of the members served.

8. Provide opportunities for members to participate in meaningful integrated community activities.
 9. Produce outcomes of increased individual skill development toward outcomes identified in the member's plan.
 10. Assist members in achieving and maintaining a quality of life that promotes the member's vision of the future.
- B. Service Settings (Day Treatment and Training)
1. Children ages birth to 48 months may not be appropriate for this service. Any considerations to provide this service to this age group requires approval from the District Program Manager or designee.
 2. This service is not provided in a group home, developmental home (child or adult), hospital, skilled nursing facility, non-state operated Intermediate Care Facility (ICF), or Level I or Level II behavioral health facility.
 3. For members under age 18, services are provided in a Qualified Vendor owned/leased setting or a publicly available setting where members participate in a supervised program.
 4. For adult members age 18 or above, services are provided in a Qualified Vendor owned or leased setting or a publicly available setting where members participate in a supervised program. The primary use of this setting is the operation of a day program, not as a permanent residence, unless approved by the Division's District Program Manager or designee.
 5. All Day Program settings in a provider's owned/leased setting require a Life Safety Inspection by the Division's Office of Licensing Certification and Regulation (OLCR).
- C. Service Requirements (Day Treatment and Training)
- Before Day Treatment and Training can be authorized, the following requirements must be met:
1. Members between the ages of 16-65 years must be assessed and considered for employment supports and services.
 2. The Planning Documents must identify needs and outcomes consistent with the service description and setting.
 3. Training and instruction must be pertinent to the present developmental, physical, mental, and/or sensory abilities of the member.

D. Target Population (Day Treatment and Training)

Using the assessment and plan development processes described in in this policy manual, the Planning Documents must determine the need for this service according to the following age categories:

1. Age 36 Months - 5 Years of Age

Generally children of this age range receive instruction from public schools in accordance with Part B of Public Law 105-17. However, the provision of Day Treatment and Training by the Division may be appropriate, if **all** of the following conditions are met:

- a. The Planning Document identifies needs above and beyond those identified in the Individualized Educational Plan (IEP).
- b. The additional hours of Day Treatment and Training are reasonable and normal for the child's age, considering the number of hours the child is participating in pre-school programs and other out-of-home activities.
- c. The child's developmental needs can best be met in a group setting.
- d. Family and other community resources are not available to meet the need.
- e. No other service is more appropriate.

2. Age five - 12 Years of Age

- a. Generally, children with developmental disabilities have their instructional needs met by the public school system. Therefore, most children do not need or receive Day Treatment and Training when they are eligible for public education services.
- b. For children five to 12 years old, Arizona Health Care Cost Containment System (AHCCCS) does not pay for child care or Respite as an alternative to Day Treatment and Training services. The Division may consider providing Day Treatment and Training for this age group if all the requirements for the three to five years age group are met and if the child needs to develop appropriate social and behavioral interaction skills and opportunities to integrate with peers who do not have disabilities.
- c. If the Division considers Day Treatment and Training services for children five to 12 years of age, habilitation goals and objectives must be established and documented in the Person Centered Plan/Child and Family Team Plan. The Division may also consider providing Day Treatment and Training services, when the member is eligible for an Extended School Year Program. This may indicate a need for Day Treatment and Training to be provided in the summer. Habilitation

goals and objectives must also be documented in the respective plans (referenced in "c" of this section) for Day Treatment and Training services for the summer.

3. Age 13 - Graduation from High School (18 - 22 Years of Age)
 - a. Generally, members with developmental disabilities have their instructional needs met by the public school system. Therefore, most members do not need or receive Day Treatment and Training when they are eligible for public education services.
 - b. The Division may consider providing Day Treatment and Training for this age group, if all the requirements for the three to five years age group are met.
 - c. For members of working age, Day Treatment and Training may only be authorized after the individual has been assessed and considered for employment supports and services.
 - d. The Support Coordinator must determine that community resources are unavailable to meet member needs, especially as related to independent living, communication, and social relationships. If the Division considers Day Treatment and Training for this age group, habilitation goals and objectives must be established and documented in the Individual Support Plan/Person Centered Plan only after consideration of employment supports and services.
4. Adults
 - a. For members of working age, Day Treatment and Training may only be authorized after the individual has been assessed and considered for employment supports and services.
 - b. Day Treatment and Training should enable members to increase their range of independent functioning and to refine their personal living skills. The service must be age appropriate.
 - c. Members participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

E. Exclusions (Day Treatment and Training)

The provision of Day Treatment and Training cannot:

1. Substitute for Respite or day care
2. Be used in place of regular educational programs as provided under Public Law 105-17 (www.gpoaccess.gov/plaws/)

3. Be used to provide other related services that have been determined in the IEP to be educationally necessary
 4. Be used when another service, such as an employment service, is more appropriate
 5. Include wage-related activities that would entitle the member to wages.
- F. Service Provision Guidelines (Day Treatment and Training)
- Use of Day Treatment and Training is in accordance with the Individual Support Plan/Person Centered Plan (Planning Documents).
- G. Provider Types and Requirements (Day Treatment and Training)
1. Designated District staff ensure that all contractual requirements related to Day Treatment and Training providers are met before services can be provided.
 2. All providers of Arizona Long Term Care Services (ALTCS) must be certified by the Department and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.
- H. Service Evaluation (Day Treatment and Training)
1. The Support Coordinator must continually assess the quality of services provided to members with developmental disabilities.
 2. Written Progress Reports
 - a. The provider must submit a written progress report on Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents) outcomes, as required by the Division's Provider Manual Progress Reporting Requirement, to the Support Coordinator. The report must address the presence or absence of measurable progress toward the member's goals and outcomes.
 - b. Each month, the Support Coordinator must review these reports for progress toward outcomes. If there is no progress in the time period specified, the member with his/her Individual Support Plan/Individualized Family Services Plan/Person-Centered Plan (Planning Team) must reassess the outcomes and determine the on-going appropriateness of the service or outcome.
 3. The Support Coordinator must review the Planning Documents as noted in the Division Operations Manual Policy 2003, Planning Documents.
 4. The provider must maintain a monthly activity schedule based on the goals and preferences of the persons supported.

5. The program must furnish materials, supplies, and equipment used to deliver Day Treatment and Training that meet the needs of the member and are age appropriate.
- I. Service Closure (Day Treatment and Training)
- Service closure occurs in any of the following situations:
1. Based on the member's progress, the Planning Documents determine that goals have been met.
 2. The member/responsible person declines the service.
 3. The member moves out of state.
 4. The member transitions to another age/skill appropriate service or program, or the member/responsible person/family can now meet the needs the service addressed, as identified in the Planning Documents.

Employment Supports and Services

- A. Employment First Principles
1. The Division supports Employment First Principles, Policy and Practice which include the following:
 2. Competitive integrated employment is the preferred daily service and outcome for all working age Arizonans who have disabilities.
 3. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.
 4. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.
 5. It supports an overarching goal that eligible persons with disabilities will have access to integrated work settings most appropriate for them, including the supports necessary to help them succeed in the workplace.
 6. Employment First does not mean employment only and does not deny individual choice.
 7. Employment First does not eliminate service options currently available but is intended to increase employment opportunities.
 8. Employment Services are provided according to this policy and Arizona's Employment First Strategic Plan and MOU, which can be found at the Employment First website.

B. Service Description and Settings (Employment Supports and Services)

These services provide opportunities for employment, using several models to support members in a variety of job related settings. The Division supports Employment First policy and practice, which means that employment should be the preferred daytime activity for members of working age.

1. Individual Supported Employment provides job coaching support, at a competitive job site, with the employed member and/or employer. Individuals receiving Individual Supported Employment work with people without disabilities and earn wages at the same rate as others in the community doing the same work. This service helps ensure that the member maintains employment and may also include job search services, if these services are not available through Vocational Rehabilitation Services. Individual Supported Employment cannot be provided in a group supported employment setting.

Members receiving this service must be paid by the employer. Individual Supported Employment is a time-limited service, which must be provided on a member basis, and can be used for members who are self-employed.

2. Group Supported Employment is a service that provides members with an on-site, supervised, paid work environment in an integrated community setting. Settings may include enclaves, work crews, and other integrated work sites.
3. Center Based Employment is a service that provides a controlled, protected and supervised work environment. This service is provided in a Qualified Vendor-owned or leased setting where the majority of the members have disabilities and are supervised by paid staff. If certain criteria are met, the member may be paid a sub-minimum wage. The service goal is to provide members with gainful, productive, and remunerative work.
4. Employment Support Aide services provide members with one-to-one supports needed to enable them to remain in their employment. These supports may include personal care services, behavioral intervention, and/or "job follow along" supports, and they may be provided in any of the above service settings, as well as a stand-alone service.
5. Split programming may be appropriate for members who desire to participate in multiple employment supports and services. Providers bill these services hourly and base them on team agreement and assessed need. Split programming is designed to fulfill the needs and desires of the members. Members participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

C. Transition to Employment (Employment Supports and Services)

Transition to Employment is a service that provides:

1. Training in the meaning, value and demands of work and in the development of positive attitudes toward work
2. Individualized instruction, training, and supports to promote skill development for integrated and competitive employment.
3. Opportunities for members to engage in job shadowing and job exploration. This service provides no pay to the member.

D. Transportation Services (Employment Supports and Services)

Transportation, to and from work, may be available to members receiving Employment Supports and Services, when such transportation is not available from community resources or natural supports.

E. Target Populations (Employment Supports and Services)

1. Target populations are members who may benefit from Employment Supports and Services. All members of working age should be involved in employment or employment-related activities unless otherwise determined unable to work as determined by the Planning Team (Individual Support Plan/Person Centered Plan team).
2. The Individual Support Plan/Person Centered Plan meetings and monthly progress reports from providers may be used to identify the need for Employment Supports and Services. Participation in Individual Education Plan meetings/School-to-Work Transition Planning meetings, and the member's verbalized interest in employment may also identify the member's need for employment services.
3. Beginning no later than age 14, the member, with his/her Planning Team (Individual Support Plan/Person Centered Plan team), should identify the member's desired future, employment goals, and skills and abilities. The Planning Team must include a description regarding the level of support needed and documentation of these needs (including transportation) on the Individual Support Plan/Person Centered Plan.
4. Employment Supports and Services are available to:
 - a. Members who are eligible for ALTCS, based on assessed need
 - b. State-funded-only members, based on assessed need and availability of funding.

F. Rehabilitation Services Administration/Vocational Rehabilitation Referral Process (Employment Supports and Services)

The Division works in collaboration with the Rehabilitation Services Administration/Vocational Rehabilitation to coordinate the provision of employment services.

1. When the Planning Team determines that a member may be interested in competitive employment or can benefit from employment-related service, the Support Coordinator will document this in the ISP and will complete a Referral to Vocational Rehabilitation (DDD 1328-A FORFF) to Employment Services Specialist.
2. The Employment Program Specialist reviews the referral packet for completeness and appropriateness and determines whether the completed packet will be sent to Rehabilitation Services Administration/Vocational Rehabilitation Program.

G. Authorization (Employment Supports and Services)

1. The Support Coordinator adds the appropriate code to the Service Plan and submits the authorization request to the Employment Services Specialist.
2. The Employment Services Specialist reviews and approves the authorization for services.
3. The Qualified Vendor is informed in writing of service authorization and may only provide the services that have been authorized by the Division. Any change in services requires a new written authorization.

H. Service Changes (Employment Supports and Services)

Any change in Employment Supports and Service, including changes from one employment service to another or from an employment service to a different day service, requires Planning Team agreement, an updated ISP and new authorization for services.

I. Tracking and Reporting (Employment Supports and Services)

1. The Qualified Vendor must submit individualized quarterly progress reports to the Support Coordinator. The Support Coordinator ensures that Qualified Vendors submit required reports and address reported concerns.
2. If concerns cannot be resolved, the Support Coordinator contacts the District Employment Program Specialists.
3. The Qualified Vendor submits a report on Division forms every six months to the Employment Program Specialist.

J. Monitoring and Technical Support (Employment Supports and Services)

At a minimum, the District Employment Program Specialist performs:

1. An annual on-site Quality Assurance Review of all Qualified Vendors who provide Employment Supports and Services
2. A review of the Qualified Vendors' "six month" reports, on-site visits, and technical support as needed.

Hourly and Daily Habilitation

A. Description (Hourly and Daily Habilitation)

This service provides learning opportunities designed to help a member develop skills and independence.

1. Barring exclusions noted in this section, based on member and family priorities, Habilitation may be provided to:
 - a. Increase or maintain:
 - i. Independence and socialization skills
 - ii. Safety and community skills
 - iii. Member's health and safety.
 - b. Provide training in:
 - i. Essential activities required to meet personal and physical needs
 - ii. Alternative and/or adaptive communication skills
 - iii. Self-help/living skills.
 - c. Develop the member's support system to reduce the need for paid services.
 - d. Help family members learn how to teach the member a new skill.
2. When this service is authorized for a member with nursing needs, all assessed medically necessary services and supports are provided.

B. Considerations (Hourly and Daily Habilitation)

The following are considered, when assessing the need for this service:

1. Existing community support systems have been exhausted and no other service is available
2. The member's documented needs cannot be met by the member's support system, employment program, or day program
3. Habilitation can support therapy home program strategies.

C. Settings (Hourly and Daily Habilitation)

Habilitation Services may be provided:

1. Hourly or daily in the member's own home
2. Hourly in the home the member shares with the family
3. Hourly in a Department of Child Safety licensed foster home
4. Hourly in other community settings (e.g. a Habilitation provider can assist a child in participating in a private pay day care/after school program)
5. Daily in a Group Home
6. Daily in a Developmental Home.

D. Exclusions (Hourly and Daily Habilitation)

Exclusions to the authorization of Habilitation services include, but are not limited to, the following scenarios. Habilitation cannot:

1. Substitute for Respite or day care
2. Be used in place of regular educational programs as provided under Public Law 108-446 IDEA Part B
3. Substitute for funded or private pay day programs
4. Be used when another service is more appropriate
5. Be authorized when Daily Habilitation is authorized
6. Be provided in a:
 - a. Private or public school during school hours or during transit to schools
 - b. Provider's residence unless the residence is also the home of the member receiving the service
 - c. Qualified Vendor owned or leased service site.

- d. Vendor-supported Child Development Homes or Adult Developmental Homes, unless the following are met:
 - i. There is a specific issue, problem, or concern that is believed to be temporary or short term.
 - ii. The Planning Document outlines specific, time limited goals/outcomes regarding the service to be provided.
 - iii. Progress reports validate continuing the service.

Habilitation Early Childhood Autism Specialized

Description (Habilitation Early Childhood Autism Specialized)

This service provides various interventions, to maximize the independence and functioning of young children diagnosed with, or at risk of, Autism/Autism Spectrum Disorder per Division eligibility requirements. Service interventions address special developmental skills, behavior intervention, and sensorimotor development in order to prepare the child for entry into a full-time academic program. This service is designed to teach and strengthen the skills of the parent(s)/caregiver(s) through participation when this service is provided.

This service may be a combination of Habilitation Doctoral or Masters (Early Childhood-Master-ECM) and Habilitation Bachelors (Early Childhood-Bachelor, ECB). It is authorized concurrently with Habilitation Hourly (Early Childhood Hourly, ECH) and must be provided to one child at a time, with the participation of the child's parent(s)/caregiver(s). The ECM, ECB, and ECH service codes are authorized to the same Qualified Vendor.

Service hours provided by the Masters-Level Consultant and the Bachelors-Level Consultant combined may not exceed 250 hours per child for a two-year period. Prior to the end of the two-year authorization period, all progress reports will be reviewed to determine the child's progress and the continued need for the service. If the service is determined to be medically necessary, based on the review of the data and documentation, authorization is issued in six-month increments (six units per month) as long as medically necessary, but only until the child is eligible for a first grade school program.

No additional hours of ECM/ECB will be authorized in the extension period until the initial 250 hours have been exhausted.

Barring exclusions noted in this section, ECM and ECB may include:

- A. Habilitation Doctoral or Masters (ECM) (Habilitation Early Childhood Autism Specialized)

An ECM consultant provides the functions below:

- 1. Up to 20 hours for the initial intake and assessment, including :
 - a. Completion of the Vineland Scales of Adaptive Functioning, Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Learning and Language Skills (ABLLS), and/or

- other standardized tool(s) to measure baseline adaptive functioning as approved by the Division
- b. Development of the intervention plan that explains targeted goals and objectives, including an operational definition for each behavior and/or skill and how goals/objectives will be measured, as follows:
- i. Identify member's baseline and current level of functioning.
 - ii. Describe the behavior that the member is expected to demonstrate, including condition(s) under which it must be demonstrated.
 - iii. State date of introduction of each goal/objective.
 - iv. Estimate date of mastery for each goal/objective.
 - v. Specify plan for generalization of the mastered skill/behavior.
 - vi. Specify behavior management (behavior reduction and/or skill acquisition) procedures:
 - Antecedent-based interventions (e.g., environmental modifications, teaching interventions)
 - Consequence-based interventions (e.g., extinction, scheduling, reinforcement ratio).
 - vii. Describe data collection procedures and how progress toward goals will be measured to reflect the increase or decrease of skills or behaviors.
- c. Summary of the parent(s)/caregiver(s) involvement and proposed goals/objectives, including a description of:
- i. Behavior that the parent(s)/caregiver(s) is expected to demonstrate, including conditions under which they will demonstrate mastery
 - ii. Date of introduction of each goal/objective
 - iii. Estimated date of parent's/caregiver's mastery of each goal/objective
 - iv. Parent(s)/caregiver(s) training procedures
 - v. Data collection procedures.
- d. Number of Habilitation (ECH) hours necessary to implement the plan based on identified interventions specific to the child's needs.

- e. A description for how this service will be coordinated with other services or therapies that the child is receiving from the Division or other sources (e.g., Behavioral Health, Health Plan, Education, Child Welfare).
 - f. A plan for transitioning the child from the service:
 - i. Include individualized discharge criteria developed with specific, realistic, and timely follow-up care coordination recommendations.
 - ii. Include plan for maintenance and generalization, including how and when this service will be transitioned to other lesser intensive services.
 2. Regular consultative oversight to parent(s)/caregiver(s) and ECH providers, using the remaining hours within the initial 250 hour authorization.
 3. Quarterly reports, provided in writing, to include the areas identified in the Division's Provider Policy Manual Chapter 35 Progress Reporting Requirement.
 4. Reassessment using the Vineland Scales of Adaptive Functioning or other industry accepted tool to be administered annually, at a minimum.
- B. Habilitation Doctoral or Masters (ECM)/Habilitation Bachelors (ECB) (Habilitation Early Childhood Autism Specialized)
- An ECM or ECB consultant provides the functions below:
1. Training, for the parent(s)/caregivers(s) and habilitation provider(s) within the first 90 days of service, that includes:
 - a. Modeling implementation of the specific activities with the child while the Habilitation provider(s) and or parent(s)/caregiver(s) are observing
 - b. Observing the Habilitation provider(s) or parent(s)/caregiver(s) implement the plan.
 2. With the hours remaining in the initial 250 hour authorization, providing regular consultative oversight to parent(s)/caregivers(s) and habilitation provider(s).
- C. Habilitation (ECH) Hours-Habilitation (Habilitation Early Childhood Autism Specialized)
1. The number of ECH hours is determined by the ECM Consultant's assessment and prior authorized by the Division.

2. The approval of ECH hours as recommended in the ECM Consultant's assessment and authorized by the Division must be coordinated with the authorization of the ECM/ECB hours (the approval of ECH and ECM/ECB are for the same service period and terminate at the same time).
 3. The ECH provider will follow the plan/treatment goals developed by the ECM/ECB Consultant when authorization of habilitation hourly is in conjunction with the ECM/ECB program.
- D. Responsible Person(s)' Participation (Habilitation Early Childhood Autism Specialized)

This service requires participation from parent(s)/caregiver(s) to maximize the benefit of the service and improve outcomes for the child. As part of this service, parent(s) and caregiver(s):

1. Must participate in training provided by a qualified ECM/ECB Consultant on the specific activities developed for their child
 2. Must implement the intervention plan (specific strategies) developed by the ECM/ECB Consultant as described in this section
 3. Are expected to attend and participate in the ECH sessions, which include the ECM or ECB Consultant, and to implement the program during the course of treatment. Attendance and participation help to ensure that the goals important to the family are included and to provide additional guidance on the specific strategies.
- E. Considerations (Habilitation Early Childhood Autism Specialized)

Using the assessment and plan development processes described in this policy manual, the Support Coordinator must consider the following factors when assessing the need for this service:

1. Eligibility for this service must be determined prior to the age of five.
2. The child must be eligible for the Division under the diagnosis of, or at risk of, Autism/Autism Spectrum Disorder AND be eligible through the Arizona Long Term Care System (ALTCS) program.
3. Parent(s)/caregiver(s)' ability and interest in participation in service delivery:
 - a. The ECM Consultant must identify a clinical reason for lack of participation and document this reason in the Planning Document (e.g., the presence of the parent(s)/caregiver(s) interferes with the teaching of a specific skill/task).
 - b. When the parent(s)/caregiver(s) is unable to participate, the team must identify other natural or paid supports, including services that allow the parents to participate.
4. Identification of the need in the child's Planning Document.

F. Settings (Habilitation Early Childhood Autism Specialized)

This service may be provided:

1. Hourly, in the child's home
2. Hourly, in other community settings or activities (unless specifically excluded below).

G. Exclusions (Habilitation Early Childhood Autism Specialized)

1. This service must not be provided in school or in transit to and from school.
2. The ECH portion of this service must not be provided in conjunction with the hourly habilitation (HAH) service.

1240-G HOME NURSING

REVISION DATE: 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: C.F.R. 42-440.80.

Service Description and Goals (Home Nursing)

This service provides nursing intervention in the member's place of residence. Services may include patient care, coordination, facilitation, and education.

Home health nursing includes intermittent and continuous nursing services as described in Chapter 1200 of the Arizona Health Care Cost Containment System (AHCCCS) Policy Manual (Policy 1240) www.azahcccs.gov/.

Intermittent Nursing Services

Intermittent nursing services must be ordered by a physician and provided by a registered nurse or a licensed practical nurse. Skilled nursing assessments are required for monitoring purposes. The service provider must also submit written monthly progress reports to the member's primary care provider or attending physician for intermittent nursing services.

Continuous Nursing Services

Continuous nursing services/home health private duty nursing must be ordered by a physician and provided by a registered nurse or a licensed practical nurse in accordance with 42 CFR 440.80 (www.gpo.gov). Continuous nursing services may be provided for members who are Arizona Long Term Care System (ALTCS) eligible and reside in their own home. Continuous nursing services are provided as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of intermittent nursing care and when determined to be cost-effective.

The goals of this service are to:

- A. Increase or maintain self-sufficiency of eligible members; and,
- B. Improve or maintain the physical well-being of eligible members.

Service Settings (Home Nursing)

The service shall not be provided in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), Nursing Facility (NF) or hospital.

Service Requirements (Home Nursing)

Before Home Nursing can be authorized, the following criteria must be met:

- A. All members receiving this service shall have a nursing assessment done by a Division Nurse to determine skilled intervention, which includes:

1. A review of the current medical files, including all pertinent health-related information, to identify potential health needs of the member related to the Division nursing assessment;
 2. Assessment of the health status of the member by a review of the current medical data, communication with the member, team members and families, and assessment of the member in relation to physical, developmental and behavioral dimensions; and,
 3. When home nursing services are identified by the Division Nurse, a referral is submitted to the Division contracted home health nursing providers. The home nursing service provider must obtain an order from the primary care provider to perform duties related to home nursing care.
- B. A licensed primary care provider must prescribe the services as a part of a written “plan of care.” This “plan of care” must be reviewed and recertified by the primary care provider at least every 60 days.
- C. The service shall follow a written nursing plan of care developed by the Division contracted Home Health provider, in conjunction with the Division's Support Coordinator, the member/responsible person and the Division Nurse which includes:
1. Specific services to be provided;
 2. The person who will provide the specific service;
 3. Anticipated frequency and duration of each specific service;
 4. Expected outcome of services;
 5. Coordination of these services with other services being received or needed by the member;
 6. Input of the member/responsible person; and,
 7. Assisting the member in increasing independence.

The nursing plan of care shall be included in and reviewed by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team).

Target Population (Home Nursing)

Support Coordinators will identify members who potentially need nursing through the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan process (Planning Process) and will submit a referral to the Division Nurse. The Division Nurse upon referral from the Support Coordinator will complete a nursing assessment and if the need is justified, a referral will be made to a contracted Division nursing agency. The contracted Division nursing agency will be responsible to obtain a written order from the primary care provider to perform the duties of home nursing care. The allocation of skilled nursing care

hours is determined by the Division Nurse; based on the nursing needs identified on the Division nursing assessment.

Exclusions (Home Nursing)

Exclusions to the provision of Home Nursing include:

- A. Nurses may not provide service under physician's orders and prescribed medical procedures that have been changed by someone other than the physician;
- B. Nurses may not be paid to provide other services, such as personal care during the time they are providing home nursing; .
- C. Home nursing shall not be used for day care; and,
- D. Nurses shall not provide direct supervision of non-licensed persons engaged in service provision.

Service Provision Guidelines (Home Nursing)

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Nursing being provided. The Division Nurse will complete this assessment.

Provider Types and Requirements (Home Nursing)

Designated District staff will ensure all contractual requirements related to Home Nursing are met before services can be provided. Additionally, all providers of, ALTCS must be certified by the Division and registered with the AHCCCS prior to service initiation.

Service Evaluation (Home Nursing)

- A. Written assessment shall be completed quarterly by the Division Nurse, maintained on file and a copy sent to the Support Coordinator.
- B. The Division contracted home health provider shall complete a nursing care plan and submit a copy to the Division Nurse and the Support Coordinator.
- C. Each nursing plan of care from the Division contracted home health nursing provider shall be updated at least every 60 days. Any revisions to the plan shall be sent to the Division Nurse and the Support Coordinator.
- D. All physician orders shall be maintained and implementation documented in each member's file.
- E. Any contact made on behalf of the member shall be documented.

Service Closure (Home Nursing)

Service closure should occur when assessments by the Division Nurse, in conjunction with the Support Coordinator, indicate no further need for skilled nursing.

- A. The Division Nurse is to inform the primary care provider that skilled nursing service is no longer required.
- B. The Division Nurse is to inform the Division contracted home health provider that skilled nursing service is no longer required. The Division contracted home health provider is to obtain a discharge order from the primary care provider.

In addition to the member's home, nursing services may also be provided in Group Homes, Developmental Homes, Level I and Level II Behavioral Health Facilities, or Day Treatment and Training programs as appropriate.

1240-H HOME HEALTH AIDE

REVISION DATE: 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

Service Description and Goals (Home Health Aide)

This service provides intermittent medically necessary health maintenance, continued treatment or monitoring of a health condition, and supportive care for activities of daily living at the member's place of residence. A Home Health Aide serves as an assistant to the primary caregiver, under the supervision of a licensed, registered nurse following a plan of care based upon the member's medical condition as prescribed by the Primary Care Provider (PCP), and authorized by Health Care Services (HCS).

The goal of this service is to increase or maintain self-sufficiency of eligible members.

Service Settings (Home Health Aide)

Home Health Aide services are provided in the member's home, but are not provided in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) Nursing Facility (NF) or hospital.

Service Requirements (Home Health Aide)

- A. This service shall be supervised by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse. The agency supervisor shall conduct home visits at least every 60 days.
- B. The service shall follow a plan of care developed by the supervisor, member and provider, in accordance with the PCP, which includes monitoring vital signs; changing dressings and/or bandages; care and prevention of bedsores; assistance with catheter (not to include insertion); assistance with bowel, bladder and/or ostomy program; assistance with self-medication; nail and skin care; assistance with personal hygiene; assistance with eating; assistance with ambulation, range of motion and exercise activities; assistance with special appliances and/or prosthetic devices; and transfers to and from wheelchair.
- C. The service may include teaching the primary caregiver how to perform the home health tasks contained in the plan of care.
- D. The service must be prescribed by a licensed physician as part of a written plan of care that shall be reviewed and recertified by the physician at least every 60 days.

Target Population (Home Health Aide)

This service is indicated for members who have a health condition that requires intermittent assistance, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan.

Exclusions (Home Health Aide)

Exclusions to the provision of Home Health Aide services include, but are not limited to:

- A. Home Health Aide service shall not be used in place of another, more appropriate service such as Personal Care or Habilitation; and,
- B. Home Health Aides shall not provide skilled nursing services.

Service Provision Guidelines (Home Health Aide)

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Health Aide service being provided. This assessment may be done by the District Utilization Review Nurse or by a nurse from HCS. Approval for this service must come from HCS.

Provider Types and Requirements (Home Health Aide)

Designated District staff will ensure all contractual requirements related to Home Health Aide providers are met before services can be provided. Additionally, all providers of Arizona Long Term Care Services (ALTCS) must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

Service Evaluation (Home Health Aide)

- A. The physician will review the plan of care at least every 60 days and prescribe continuation of the service.
- B. The agency nurse supervisor will review the plan of care at least every 60 days for appropriateness.
- C. The provider will submit progress notes on the plan of care on a monthly basis to the Support Coordinator.

Service Closure (Home Health Aide)

Service closure should occur in the following situations:

- A. Based on the plan of care, it is determined by the physician that the service is no longer needed;
- B. The member/responsible person decline the service;
- C. The member moves out of state;
- D. The member requires other, more appropriate services (e.g., home nursing or personal care); and,
- E. The member/responsible person has adequate resources or other support to provide the service.

1240-I HOME MODIFICATIONS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: June 30, 1994

REFERENCES: A.R.S. §§ 41-1491.19.D.1 and 32-1101.01.

Overview

Home Modification is the process of adapting the home to promote the independence and functional ability of persons with disabilities. Adaptations may include physically changing portions of the residence to create a living environment that is functional according to the member's specific needs. Terms often associated with this process include barrier removal, architectural access, assistive technology, retrofitting, home modifications, environmental access, or universal design.

Members who are eligible for the Arizona Long Term Care System (ALTCS) are also eligible for medically necessary home modifications for architectural access to and within his/her natural/private home. The goal of a home modification is to provide the person greater independence and ability with assistance for daily living in their home. Home modifications must be medically necessary, cost-effective, and reduce the risk of an increase in Home Community Based Services (HCBS) or institutionalization.

A Home Assessment will be done to develop an individualized home modifications plan. The plan will ensure that only appropriate diagnosis related modifications be completed in the home. This plan also provides for a cost-effective, predictable, medically beneficial, and measurable rehabilitative service for the member.

The Division must approve or deny requests for home modifications within 14 calendar days from the "identified need date." A request that requires an additional extension for up to 14 days and is in the member's best interest. Requires the member receive written notice including the reason for the extension. The Support Coordinator should request an assessment via the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process when attempting to identify the most appropriate modification for the member. The Planning Team identifies the need for a home modification assessment only. The assessment must be completed within 30 days. A certified staff person must conduct a home visit to make this assessment. The "identified need date" is determined at the time the team agrees to the recommendations as a result of the assessment.

When a request is for a specific home modification, such as a curbless shower, "handrails," or widen doors, the Support Coordinator via the Planning Document can make a request for that specific modification. The "identified need date" starts at this time and the request for home modifications must be approved or denied within 14 days. A request that requires an additional extension for up to 14 days, and is in the member's best interest, requires the member receive written notice including the reason for the extension. This method may result in a denial of service. The home modification unit would make a broad "contingent" recommendation if sufficient evidence is present to move forward with the request.

Scope of Home Modifications

The unit of service is one home modification project. Using the member's primary and secondary diagnoses in conjunction with a home evaluation, a project plan to provide home

modification for the person will include, but not be limited to, the following areas of the home:

- A. Member's bedroom;
- B. Most appropriate, cost-effective bathroom;
- C. Most appropriate, cost-effective entrance/exit to the member's home, i.e., a ramp; and,
- D. Most appropriate, cost effective locations of the kitchen area, when determined to be medically necessary when the member lives alone.

The types of permanent installations for architectural barrier removal include:

- A. Widening of doorways – entrance and exit to one bathroom and the member's bedroom;
- B. Accessible routes to one bathroom and the member's bedroom;
- C. One bathroom environment; (roll-in/curb-less) accessible shower, roll-under sink, high rise toilet with handrails, handrails and grab bars in accessible shower, as prescribed;
- D. One wooden or concrete ramp/low inclined walkway; and,
- E. Kitchen modifications; accessible cooking surface, minimum accessible pantry storage, accessible kitchen sink/faucet. Kitchen modifications are considered medically necessary when the member lives alone and cannot independently prepare necessary meals without modifications.

Home Modification recommendations (e.g., curb-less showers) will consider the use of durable medical equipment (e.g., shower chair) to be used; the Health Care Services Office can provide technical assistance on durable medical equipment. The member must request any new Durable Medical Equipment via their Primary Care Provider (PCP) who forwards the need to their contracted health plan.

Home Repairs, Home Improvement

General home repairs and maintenance are the responsibility of the homeowner. Home Modifications are for medically necessary environmental access and do not intend to include remodeling for home improvement or home safety. Although home safety is an outcome from architectural barrier removal when home modifications have been completed, it is the responsibility of the homeowner to ensure the home is safe; and to maintain important safe entrances from the home in case of emergency, for all inhabitants. Requests for home modifications that are determined to be for home repairs, home improvement, or home safety will be denied.

Repairs will be carried out to existing structures only when the approved modifications have begun and cannot be completed because of unforeseen circumstances. These repairs must

necessary for building code correction, thereby granting the building contractor the ability to achieve completion of approved medical environmental modifications.

New Construction

The service covers only modifications to existing structures of a member/family owned home where the person resides. Members/families that are planning for a new home are responsible for all the architectural access design/construction of a new home. The service does not cover the construction of additional rooms to the existing structure or provide for an additional bathroom. Technical assistance may be available to help with environmental access.

Homes Not Owned by the Member (Rental/Lease)

The owner of the residence must approve the modifications. When the home being considered for home modifications is not owned but is rented or leased by the family/member, documentation providing permission to allow for renovations on behalf of the member is required from the landlord/owner. Written confirmation must include agreement of participation, signature of the landlord/owner with indication of ownership, and address of residence requested for environmental access.

The Division will incur the cost to restore the home to the original condition prior to the renovation when the landlord/owner requires such after the member has vacated the property.

No Title XIX funds may be used to return a home to its pre-modification state as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy (www.azahcccs.gov/Regulations).

It will be the responsibility of the landlord/owner to demonstrate that the removal of architectural barriers in the rented unit will result in the inability to negotiate a new rental agreement with another member or family. The landlord/owner must also demonstrate that it is a financial disadvantage to maintain environmental access to the rented unit. Additionally, the landlord/owner must demonstrate that the unit will not retain the retail value of a single family dwelling because of the removal of architectural barriers.

Requirements for Medically Necessary Environmental Modifications

Requests for the environmental access to the person's home must include all of the following:

- A. The need for environmental access documented in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan;
- B. ALTCS Primary Care Provider order;
- C. An assessment by a qualified professional, e.g., Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant. The Division's Medical Director must be contacted to review the request if an assessment by a qualified professional cannot be obtained;

- D. An authorization by the Home Modifications Manager; and,
- E. The evidence that the member resides in a private residence. Members residing in alternative residential settings are not eligible to receive Home Modifications.

If the request is denied due to lack of medical necessity, it may be authorized, approved or paid by Assistance to Families funds. Medically contraindicated requests shall not be authorized.

Procedures

When a member has recognized a need for home modifications, a request for a home modification begins by contacting the member's Support Coordinator.

The Support Coordinator will forward the request to the Home Modifications Office using the "Initial Request for Home Visit" fax form upon receipt of a member's request for a home modification. This request must be made via the Individual Support Plan/Person Centered Plan process. A written order by a Primary Care Provider (PCP) is another way to make this request. Requests for a home modification may also be made using a home assessment from a Physical/Occupational Therapist. At the time of request for home modifications the Support Coordinator shall enter into the case file via the "Individual Support Plan" or the "Change of Individual Support Plan" form, the need for an assessment to determine specific modifications.

The date recorded in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) becomes the date for the request for an assessment. This request date determines the beginning of the required 30 days to complete a home visit and assessment. Once the assessment is completed, the team can request the specific modifications and the date of this request becomes the "need identified" date.

The Division must approve or deny requests for home modification within 14 days of the identification of need date. A request that requires an additional extension for up to 14 days and is in the member's best interest, requires the member receive written notice including the reason for the extension. Projects should be completed as soon as possible following approval, not to exceed 90 days. Extenuating circumstances that prevent project completion within 90 days of approval will be documented in the member's case record.

A scheduled home assessment will be conducted within 30 days after the Home Modification unit in Central Office receives a request. The Support Coordinator must be present during the home environmental assessment.

The purpose of a home modification is to increase a member's independence. The home visit will assess the relationship of the member's ability to function independently in the current environment as a result of the proposed home modifications. The home visit will also coordinate the Home Modification Packet production.

The home assessment will include:

- A. Consideration for member's abilities and disabilities based upon aids to daily living;

- B. Consideration of information that is obtained from the member, family or others in the household and members of the Planning Team;
- C. Consideration of hazardous areas of the home based on physical and/or cognitive/intellectual disabilities;
- D. Identification of the Planning Documents needs as they relate to delivering services to the member;
- E. Identification of diagnosis-related modifications;
- F. Provisions for necessary assistive devices and durable medical equipment;
- G. Provisions for necessary architectural barrier removal; and,
- H. Recording architectural measurements of floor plans and specification sheet.

Review the required documents for the Home Modifications Packet with the member's Support Coordinator. This includes:

- A. Reviewing the Professional Assessment for environmental access. An Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant for the project can provide the professional assessment. A review may be requested from the Division's Medical Director if a professional assessment cannot be obtained at all or obtained in a timely fashion.
- B. Obtaining the PCP order for the project using the prescription form approved by the AHCCCS at 15 days from the "need identified" date. After this 15-day period, the Home Modifications unit will send a second prescription form to the PCP with instructions that services will be denied if the prescription form is not received.
- C. Obtaining the Project Specification Sheet and Floor Plans. The Home Modification Office will be responsible for the development and implementation of the Project Specification Sheet and drafting of floor plans for each Project. A bid request will be forwarded to the appropriate providers. The Home Modifications Unit will review and award the bid to the approved provider upon return of the proposal.
- D. The following authorities will be used as reference for determining accessibility and defining a living environment that provides greater independence and architectural access for the member upon developing the Project Specification Sheet. These include Uniform Building Code Chapter 11 - Accessibility, and guidelines in accordance with the Americans with Disabilities Act. *Note:* The Division will only approve medically beneficial, cost-effective environmental access.

Obtain Home Modification Bids - (at least two (2) bids). The Division will use only a licensed, bonded/insured - B or B3 Contractor/Builder for the accessible renovation of the member's residence.

Complete the *Environmental Modifications Request Form* to track progress of the project. Ensure that member's identification information, Provider/Contractor name, cost of service, the signatures of the Support Coordinator, supervisor, and District Program

Administrator/District Program Manager or designee (cost of service must be indicated prior to submitting to the Lieutenant Program Manager/District Program Manager) are included. The project can be approved and started whether or not the form has been completed but must be completed to ensure everyone has knowledge of the project and the project costs.

Submit the project packet to the Home Modification Office for review/approval.

The packet will include the following:

- A. Environmental Modifications Request;
- B. Member's Planning Documents (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan) indicating need for medical environmental access;
- C. Professional assessment dated within time of request or review with signature from Division's Medical Director;
- D. PCP order dated within time of request;
- E. Project Specification Sheet and Floor plan (before and after, site plan); and,
- F. Contractor bids.

Review Procedures

The Home Modifications Manager will ensure the District representative has reviewed costs and signatures are present upon receipt of the Project Packet.

The Home Modifications Manager will review and sign the request only upon verification that all necessary documents have been provided.

A second level of approval will be required if a Home Modification Project Packet has a total project cost greater than \$9000.00. The Home Modifications Manager will forward the project packet to the Assistant Director or designee for review and a final decision. The second level review will be monitored as to avoid delay and maintain Project Packet progress with in required time frames.

1250-B HOSPICE

REVISION DATE: 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

Service Description and Goals (Hospice)

Hospice services significantly impacts members/families served by the Division who are in the process of making end of life decisions. The Division is determined to ensure that the existence of a member's disability bears no influence on end of life decisions and is committed to protect the best interest of people with developmental disabilities.

The Division is also determined to ensure that the decision to provide life-sustaining treatment to members is determined by using the same standards of judgment used to assess the same decisions regarding persons without developmental disabilities.

The Division is opposed to decision-making to hasten death due to the perception that people with developmental disabilities have a "low quality of life" and believes that the lives of all people are valuable. As a result, the Division is committed to helping members obtain the best care possible. The Division also believes that treatment should be conducted in accordance with the member's wishes or what is understood to best represent the member's best interests.

Situations may arise where the burden of medical treatment outweighs the benefit to the member. The Division is aware of situations where members, families, and health care providers weigh the benefits of care when there is no hope for improved health and the prolonging of life no longer benefits the "patient."

The Division discourages the removal of life sustaining devices. If the member, surrogate, and medical experts determine that life sustaining devices are not in the member's best interest, they may determine other options. A member's disability should not be a determining factor when considering whether or not to remove life sustaining devices.

First, treatment that provides no discomfort and alleviates pain may be continued. Next, treatment that needlessly prolongs suffering may be eliminated while maintaining those devices that allow for comfort and rest. Finally, all life sustaining devices may be removed in an effort to allow the progression of natural events to take place, unless the cessation of certain devices would cause pain and discomfort.

Division staff confronted with end of life situations shall do the following:

- A. Share the Division's perspective on the lives of members;
- B. Emphasize that the member's disabilities should not influence medical decisions;
- C. Encourage cooperation, and open communication to determine the member's best interest with family members, surrogate decision makers, and health care providers; and,

- D. When a member has an advanced directive, durable power of attorney, health care directive power of attorney, or any such legal document, the Division respects the member's lawful wishes as specified in the legal document.
- E. If there is no such legal document providing guidance in end of life situations the following need to be considered:
1. The member's ability to participate in the activities and functions that provide pleasure and value to their lives;
 2. The member's health condition;
 3. The benefit of treatment;
 4. Treatment options; and,
 5. The members best interest.

Hospice services are provided to Arizona Long Term Care System (ALTCS) members who meet medical criteria/requirements and are not based on a person's disability. Hospice services provide palliative and support care for terminally ill members and their family or caregivers. Hospice services provide health care and emotional support for terminally ill members and their families/caregivers during the final stages of life.

1250-C MEDICAL AND ACUTE CARE SERVICES

EFFECTIVE DATE: May 13, 2016

- A. Medical/acute care services provided to members eligible for ALTCS are the same as those provided to members enrolled in the acute care program, with the exception of therapies.
- B. Medical/acute care services require orders from the member's primary care provider or attending physician, and in some cases, authorization from the member's Support Coordinator.
- C. Medical/acute care services may be provided to members eligible for ALTCS residing in their own home, institutional setting, or any ALTCS approved alternative HCB residential setting.

1250-D RESPITE

REVISION DATE: 7/15/2016, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: Rate Book; AzEIP

Service Description and Goals (Respite)

This service provides short-term care to relieve caregivers. Members who are cared for by Respite providers must be eligible for supports and services through the Division. Respite providers may be required to be available on a 24-hour basis. Respite services are intended to temporarily relieve unpaid caregivers. Respite services are not intended as a permanent solution for placement or care. The number of hours authorized for Respite services must be used for Respite services and cannot be transferred to another service.

Service Settings (Respite)

Respite may be provided in any of the following settings:

- A. The member's home
- B. A Medicare/Medicaid certified Nursing Facility
- C. A Group Home, Foster Home or Adult Developmental Home certified by the Division
- D. A certified Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)
- E. A provider's home that complies with the requirements of the Department of Health Services or the Division.

Service Requirements (Respite)

Before Respite can be authorized, the following requirements must be met:

- A. Prior to initiating service, the provider shall meet with the primary caregiver to obtain necessary information regarding the member;
- B. The provider shall:
 - 1. Supervise the member and meet their social, emotional, and physical needs;
 - 2. Ensure the member receives all prescribed medications in the ordered dose and time;
 - 3. Administer First Aid and give appropriate attention to injury or illness;
 - 4. Supply food to meet daily nutritional needs including any prescribed therapeutic diets;

5. Furnish transportation as needed to day programs and appointments;
6. Carry out any programs as requested by the Planning Team;
7. Report any unusual incidents to the Division in accordance with policies and procedures; and,
8. Ensure appropriate consideration of member needs, compatibility and safety when caring for unrelated members.

Target Population (Respite)

Respite, as a medically related social service, is appropriate based upon family needs, as written in the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents). Respite services are also appropriate based on the following factors:

- A. The primary caregiver is unable to obtain Respite and other supports from his/her immediate/extended family or from other community resources.
- B. The primary caregiver needs time to recover from abnormally stressful situations in order to resume his/her responsibilities.
- C. The member with a developmental disability presents intense behavioral challenges or needs a high degree of medical care.
- D. The primary caregiver is experiencing an emergency that temporarily prevents performance of normal responsibilities.
- E. The primary caregiver requires more frequent or extended relief from care responsibilities due to advanced age or disability.
- F. The family is experiencing unusual stressors, such as care for more than one person who has a developmental disability.
- G. Respite services can only be provided for children ages 0 to 3 related to required training for the primary caregiver. This training requirement must be documented in the Individualized Family Services Plan (IFSP).

Exclusions (Respite)

Exclusions to the provision of Respite services may include any of the following:

- A. Respite shall not substitute for routine Transportation, day care, or another specific service;
- B. Respite shall not substitute for a residential placement;
- C. Respite providers shall not serve more than three people at one time;

- D. Child Developmental Homes and Adult Developmental Home providers shall not give services to more members than would exceed their Division license;
- E. Child Developmental Homes and Adult Developmental Home Respite providers shall not give services to children and adults simultaneously. This is only allowed if stated on the license. Additionally, the provider shall not offer services to adults if the license is for children and vice versa;
- F. Respite is not available for members living in Group Homes or an ICF/IID; and,
- G. Assisted Living Centers, non-state operated ICF/IID, Skilled Nursing Facilities; Level I or Level II Behavioral Health Facilities and members living independently are not approved for Respite.

Service Provision Guidelines (Respite)

- A. The federal government and the Arizona Health Care Cost Containment System (AHCCCS) set the upper limit of 600 hours per year regarding Respite services for members who are eligible for Arizona Long Term Care (ALTCS). Respite Service hours are determined on a yearly basis by the initial Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents.
- B. Members who are eligible for Respite services funded by the state are subject to the availability of these funds. The continuation of Respite services is determined on a yearly basis through the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents. Respite services are intended to allow unpaid primary care givers a break and, as such, the assessment for Respite hours will need to be reconciled with the amount of time an unpaid primary caregiver usually provides support.
- C. All hours of Respite utilized by the member/family will be tracked and reported. Respite hours for members who are eligible for ALTCS will be reported to AHCCCS.
- D. For Respite billing information see Department of Economic Security, Division of Developmental Disabilities Rate Book located on the Division's website at:

<https://des.az.gov/services/disabilities/developmental-infant>
- E. A negotiated rate will be applied for families who have more than one person eligible for Respite. This negotiated rate will be reported by the provider, with the total actual hours of service given to each member on the Uniform Billing Document. This method of rate setting will be applied when these members receive Respite at the same time. The hours used will be deducted by the Division from the authorized level of Respite for each person.
- F. Families receiving Respite for a member eligible for services from the Division who wish other non-eligible members to receive care will be responsible for the costs of serving the non-eligible member. The Division will only pay for services delivered to

members authorized to receive such service and will pay the provider at a multiple client rate.

Provider Types and Requirements (Respite)

Designated District staff will ensure all contractual requirements related to Respite providers are met before service can be provided. Additionally, all providers of ALTCS services must be certified by the Division and registered with AHCCCS prior to service initiation.

Service Evaluation (Respite)

The Support Coordinator must continually assess the quality of the services provided to members with developmental disabilities in accordance with the mission statement. Additionally:

- A. The provider shall submit attendance reports summarizing the members served and the number of hours of service to the designated District representative. All incidents shall be reported to the Division within the required timelines; and,
- B. The Support Coordinator and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall determine the on-going appropriateness of the service based upon the input from the providers and the member's caregiver(s).

Service Closure (Respite)

- A. Respite shall terminate when the member begins to live independently or in a Group Home, Vendor Supported Developmental Homes or, Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) or Nursing Facility (NF).
- B. Respite shall terminate when the family no longer desires the service.
- C. Respite for members who are eligible for services through the ALTCS shall terminate when the maximum amount allowed has been used and there are no State funds available.

1250-E THERAPIES (REHABILITATIVE/HABILITATIVE)

REVISION DATE: 7/3/2015, 3/2/2015

EFFECTIVE DATE: June 30, 1994

Habilitative Therapy

Habilitative therapy directs the member's participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in these respective documents.

Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis, and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may utilize direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

Occupational, Physical, and Speech Therapy

Description (Occupational, Physical and Speech)

Therapy services provide medically necessary activities to develop, improve, or restore functions/skills. Therapy services require a prescription, are provided or supervised by a licensed therapist, and are not intended to be long term services.

Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement, and eating.

Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

Speech therapy may address receptive and expressive language, articulation, fluency, eating, and swallowing. Barring exclusions noted in this section, Therapy includes the following:

- A. Evaluation of skills;
- B. Development of home programs and consultative oversight with the member, family and other providers;
- C. Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety;
- D. Modeling/teaching/coaching parents and/or caregivers specific techniques and approaches to everyday activities, within a member's routine, in meeting their priorities and outcomes; and,
- E. Collaboration with all team members/professionals involved in the member's life.

Responsible Person's Participation (Occupational, Physical and Speech)

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, parents/family or other caregivers (paid/unpaid) are required to:

- A. Be present and actively participate in all therapy sessions; and,
- B. Carry out the home program.

Considerations (Occupational, Physical and Speech)

The following will be considered when approving this service:

- A. Developmental/functional skills;
- B. Medical conditions;
- C. Member's network of support (e.g., family/caregivers, friends, providers);
- D. Age; and,
- E. Therapies provided by the school.

Settings (Occupational, Physical and Speech)

Therapy shall be provided in settings that support outcomes developed by the team. This includes:

- A. The member's home;
- B. Community settings;
- C. Division funded settings such as day programs and residential settings for the purpose of training staff;
- D. Daycare; and,
- E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include, but are not limited to the following:

- A. Rehabilitative therapy (acute therapy) due to an accident, illness, medical procedure, or surgery. Rehabilitative therapy includes restoring former functions or skills due to an accident or surgery.

Funding for rehabilitative therapy shall be sought from:

1. Private/third party insurance;
 2. Children's Rehabilitative Services (CRS);
 3. American Indian Health Services (AIHS);
 4. Comprehensive Medical and Dental Plan (CMDP);
 5. Arizona Health Care Cost Containment System (AHCCCS); or,
 6. Division of Disabilities (DD)/Arizona Long Term Care Service (ALTCS) Acute Health Care Plan.
- B. Physical therapy is provided by the DD/ALTCS Acute Health Care Plan for members 21 years and older and will not exceed 15 visits for developmental/restorative, maintenance, and rehabilitative therapy for the benefit year.
- C. Therapy for educational purposes.

Respiratory Therapy

Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration. The goals of this service are to:

- A. Provide treatment to restore, maintain or improve respiratory functions; and,
- B. Improve the functional capabilities and physical well-being of the member.

Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).

Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

- A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration, and scope of the therapy.
- B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association's

Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

- C. The provider shall be designated for members who are eligible for ALTCS services and registered with the AHCCCS.
- D. Tasks may include:
1. Conducting an assessment and/or review previous assessments, including the need for special equipment;
 2. Developing treatment plans after discussing assessments with the Primary Care Provider, the District Nurse and the Planning Team;
 3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member's treatment plan;
 4. Monitoring and reassessing the member's needs on a regular basis;
 5. Providing written reports to the Division staff, as requested;
 6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff;
 7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals;
 8. Consulting with members, families, Support Coordinators, medical supply representatives, and other professional, and paraprofessional staff on the features and design of special equipment; and,
 9. Giving instruction on the use and care of special equipment to the member and care providers.

Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).

Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state- operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy shall not exceed eight (8) fifteen (15) minute sessions per day.

Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of ALTCS must be registered with the AHCCCS prior to service initiation.

Service Evaluation (Respiratory Therapy)

- A. The Primary Care Provider (PCP) will review the plan of care at least every 60 days and prescribe continuation of service.
- B. If provided through a Medicare certified home health agency, the supervisor will review the plan of care at least every 60 days.
- C. The provider will submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in the following situations:

- A. The physician determines that the service is no longer needed as documented on the "Plan of Care";
- B. The member/responsible person declines the service;
- C. The member moves out of State;
- D. The member requires other services, such as home nursing; and,
- E. The member/responsible person has adequate resources or other support to provide the service.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics, and schools. The Division contracted therapists shall collaborate with other service providers and agencies involved with the member.

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

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Adaptive Aids (Acute Care Services)

Certain medically necessary adaptive aids qualify as a covered service if prescribed by a specialist physician, practitioner or dentist upon referral by a Primary Care Provider (PCP).

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment. It is important to remember that this service is based on "assessed need" and not a person's or the family's stated desires regarding specific services.

Covered adaptive aids are limited to:

- A. Traction equipment;
- B. Feeding aids (including trays for wheelchairs);
- C. Helmets;
- D. Standers, prone, and upright;
- E. Toileting aids;
- F. Wedges (positioning);
- G. Transfer aids;
- H. Augmentative communication devices;
- I. Medically necessary car seats; and,
- J. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

Augmentative Communication Devices

Service Description and Goals (Augmentative Communication Devices)

Augmentative communication devices are those devices that enhance a member's ability to communicate with others at his/her highest level of independence.

Service Settings (Augmentative Communication Devices)

Augmentative communication devices are appropriate for use in all settings.

Service Requirements (Augmentative Communication Devices)

The member and their Individual Support Plan/Individualized Family Services Plan/Person Centered (Planning Team) team must identify the need for an augmentative/alternative communication evaluation. This determination shall be made by using the Pre-Admission Screening (PAS) tool, the Inventory for Client and Agency Planning (ICAP) tool and any other available information to assess whether there may be a functional gap between the member's receptive and expressive language skills, and/or the member demonstrates communicative intent as determined by the Communicative Intent Checklist. The Support Coordinator must prepare a packet of information and forward it to Health Care Services in Central Office within 15 working days of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meeting (Planning Meeting). The packet must include all of the following:

- A. The completed Augmentative Communication Referral Checklist;
- B. The current Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) that includes long-term communication goals;
- C. A prescription for the augmentative/alternative communication evaluation and equipment as needed dated within the past 12 months;
- D. A speech and language evaluation dated within the past 12 months;
- E. The current Individualized Education Plan (IEP) if school age;
- F. Documentation of previous use of low technology devices such as picture boards or dial scanners.
- G. Occupational therapy evaluation dated within the past 12 months if the member has fine/sensory motor problems that may impact the ability to touch a small target square, to push hard enough to operate a switch or if there are limitations in the member range of motion or head control;
- H. Physical therapy evaluation dated within the past 12 months if the member has seating, positioning, and/or mobility needs related to augmentative/alternative communication device use;
- I. Formal or functional hearing test within the past 12 months;
- J. Formal or functional vision test within the past 12 months;
- K. Therapy progress reports, if therapy has been provided during the past 12 months;
- L. Third-Party Liability (TPL) insurance information;
- M. Any previous or current augmentative communication evaluation reports, if available; and,

- N. Any other reports relating to the acquisition of the skills and/or abilities necessary to operate an augmentative/alternative communication device, if available, e.g., a current psychological/psychoeducational evaluation, wheelchair/seating clinic evaluations.

An evaluation conducted by the school system is acceptable for school age members.

Health Care Services will either refer for further evaluation or order the device, as appropriate within 15 working days of receipt of the complete packet. Further evaluations may include referral to the contracted Augmentative/Alternative Communication Evaluation Team, Rehabilitation Engineering for access assessment or medical review.

Once the device is obtained, it will be sent to the Support Coordinator. The Support Coordinator delivers the device and obtains the responsible person's signature on the Acknowledgment of Receipt of Durable Medical Equipment form. This form is to be retained in the member's case record, with a copy sent to Health Care Services. Training on the use of the device will be arranged per case.

Target Population (Augmentative Communication Devices)

Members who are potentially eligible for communication systems are those who show communicative intent but whose expressive skills are currently below their receptive language skills and are not adequately meeting their day to day functional communication needs. For example, members may attempt to communicate through non-verbal approaches such as pointing, gesturing, signing, vocalizing sounds, or eye gazing. Receptive language refers to understanding of spoken language, while expressive language refers to language output (traditionally speech). Such members may be candidates for an intervention strategy that includes the use of alternative forms of expressive communication. For such a strategy to be effective, other factors must be considered to ultimately guarantee benefit to the member, e.g., the long term goal, appropriate outcomes, valuation methods, mode of learning, follow up training, and overall quality of life.

Exclusions (Augmentative Communication Devices)

Augmentative communication devices will not be provided under the following circumstances:

- A. The member has received appropriate teaching and therapeutic strategies and the prognosis for developing effective oral communication is poor;
- B. The member does not demonstrate the ability to make choices independently;
- C. The member will use the device solely in an educational setting;
- D. The member has used light/high technology communication systems and has not demonstrated the intent to communicate;
- E. The member has a history of destructive behavior and a plan of intervention has not been identified; and,

- F. The Planning Team outcomes and goals do not indicate a commitment to use the device in all settings.

Service Provision Guidelines (Augmentative Communication Devices)

The following service provision guidelines apply to augmentative/alternative communication devices:

- A. Devices will not be provided if not medically necessary and prescribed by the Primary Care Provider (PCP);
- B. One (1) device and the medically necessary accessories for operation will be provided;
- C. Only one (1) option will be provided (other options must be furnished by an alternative resource) if a device can be equipped with both voice and print capabilities;
- D. One (1) mount will be provided unless a second is medically necessary;
- E. Children under the age of 3 (who are referred as possible candidates for a device) will have their needs reviewed on a member basis. Toys are not a covered item; and,
- F. Replacement of equipment is covered in the following situations:
 - 1. Loss or irreparable damage or wear not caused by carelessness or abuse; and,
 - 2. Equipment replacement is recommended by an authorized re-evaluation. Re-evaluations for the purpose of upgrading the device will not be authorized for 6 months after the receipt of the current device.

Re-evaluations may be obtained if the current device is not meeting the member's needs despite adequate training of at least 3 months, there is a change in the member's medical condition, or communication goals were met or exceeded with the current system. Re-evaluations must include the same requirements as noted in this Chapter.

Evaluation (Augmentative Communication Devices)

The Support Coordinator must perform a review of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) as noted in this Policy Manual.

Service Closure (Augmentative Communication Devices)

All devices and accessories will be returned to the Division when no longer medically necessary as determined by the Individual Support Plan, Individualized Family Services Plan or Person Centered Plan (Planning Documents). The device and accessories must be returned to the Division if the member is moving out of state. The Support Coordinator is responsible for picking up the device and accessories and returning them to Health Care

Services. Health Care Services will then arrange for the device to be refurbished and reused.

1250-G NUTRITIONAL ASSESSMENTS & NUTRITIONAL THERAPY

REVISION DATE: 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

Supplemental Nutritional Feeding

This policy provides criteria for the evaluation and authorization of supplemental nutritional feedings (oral-enteral formula) for members eligible for Arizona Long Term Care Services (ALTCS) covered services through the Division. It also addresses the issue of medical necessity, assessment, and authorization of non-specialty formula.

Criteria for Medical Review and Prior Authorization (Supplemental Nutritional Feeding)

- A. The Primary Care Provider (PCP) or physician specialist must make the request. A Physician has requested nutritional feeding by a physician assistant or nurse practitioner. In order to make this request, the physician assistant or nurse practitioner must be under the medical management of the PCP. A request made by a physician specialist must be routed through the PCP for continuity of care. Requests shall be routed through appropriate channels of the health plan or to the Prior Authorization Nurse in Health Care Services for fee-for-service. Items to be submitted for medical review include:
1. All current diagnoses;
 2. Current or recent (within 6 months) laboratory data such as chemistry panel, iron binding studies;
 3. Growth chart with current height and weight history. A family history of unusual growth patterns, i.e., emaciated, short stature, etc. should be included, as appropriate;
 4. The history of ambulation or physical activities;
 5. The history of gastrointestinal health;
 6. A current nutritional assessment and a summary of client/caregiver education done by a registered dietitian;
 7. A 3, 5, or 7 day diary of dietary intake, as appropriate;
 8. The speech or occupational therapy evaluation related to any oral-motor, dentition, chewing, or swallowing problems, as applicable;
 9. Current medications including an analysis of possible medication/nutrient interaction affecting absorption;
 10. All alternative approaches to the use of oral-enteral formulas attempted and the outcomes; and,

11. The specific goals of oral-enteral formulas with a follow-up and weaning plan over a specific time frame.
- B. Monitoring of the client's progress on the oral-enteral formula is the responsibility of the PCP or designee and shall include:
1. Nutritional assessment follow-up at the following intervals:
 - a. Members on oral-enteral formulas less than five (5) years shall receive an assessment every three (3) months;
 - b. Members on oral-enteral formulas five (5) to fourteen (14) years shall receive an assessment every six (6) months; and,
 - c. Members on oral-enteral formulas over fourteen (14) years shall receive an assessment annually.
 2. Alternatives to commercially prepared formulas shall be considered whenever possible including blenderized foods for members beyond the normal formula age (3 years) if possible.
- C. Members who are eligible for the Arizona Supplemental Nutrition Program for Women, Infant & Children (WIC) program should be encouraged to use that program first. The Division's fee-for-service or the subcontracted health plan will make up the difference between the WIC Program, the authorized amount and the PCP requested amount.

Member Management (Supplemental Nutritional Feeding)

Members should be followed by:

- A. The health plan;
- B. The agency providing the formula; and,
- C. The Division's Health Care Services for Fee-For Service.

Authorization Process (Supplemental Nutritional Feeding)

- A. Definitions
 1. Enteral - "within or by way of the intestine." For the purposes of this policy, enteral will mean the delivery of nutritional feedings to the intestinal tract by way of a feeding tube such as nasogastric, oral-gastric, gastrostomy, jejunostomy, or a gastrostomy button.
 2. Oral - any nutritional formula or food that is ingested by mouth.

B. Authorization guidelines

1. Authorization for oral-enteral formula or supplemental nutritional feedings will be granted if the following criteria are met. The health plan Medical Director or the Division Medical Director must also deem oral-enteral formula or supplemental feedings as medically necessary for Fee for Service. The criteria for authorization are as follows:
 - a. The member is at or below the 10th percentile on the appropriate growth chart for their age, gender, or disability, e.g., Down syndrome, for greater than three months;
 - b. The member has reached a plateau in growth and/or nutritional status for greater than six months (pre-pubescent);
 - c. The member has demonstrated a decline in growth status within the last three months;
 - d. The member is able to obtain/eat no more than 50% of his/her nutritional requirement from normal food sources;
 - e. Absorption problems as evidenced by emesis, diarrhea, dehydration, weight loss, and intolerance to milk or formula products have been ruled out; and,
 - f. Unsuccessful trials of alternatives, such as blenderized foods, have been documented over a reasonable period of time with the involvement of a nutritionist.
2. The Prior Authorization Nurse will submit all documentation for evaluation by the health plan Medical Director or the Division Medical Director regarding fee-for-service.
3. Re-authorization for supplemental nutritional feeding formula will be determined by the age of the member (based on the nutritional evaluation for age set forth in this chapter).

1250-H TRANSPORTATION

REVISION DATE: 7/15/2016, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

Transportation (Non-Emergency)

Service Description and Goals (Transportation)

Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services. This service provides non-emergency ground transportation as previously approved by the Division, if the member's natural supports cannot provide such transportation.

The goal of this service is to increase or maintain self-sufficiency, mobility, and/or community access of eligible members.

Service Requirements (Transportation)

Transportation can be provided for members who are eligible for Arizona Long Term Care Service (ALTCS) to and from other covered services.

Target Population (Transportation)

- A. The need for transportation is assessed and documented by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process.
- B. Transportation is appropriate when member/family resources, supports or community resources are not adequate or available.

Exclusions (Transportation)

Exclusions for transportation services include:

- A. Providers shall not transport more members than can travel safely.
- B. Transportation for members who are eligible ALTCS to medical appointments should be coordinated through the health plan.
- C. Members residing in Vendor Supported Child Developmental Homes and Vendor Supported Adult Developmental Homes, Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Group Homes shall not receive additional transportation.

Service Provision Guidelines (Transportation)

- A. Members who are eligible for ALTCS may use forty-six (46) trips per month to covered day programs. The Division may authorize additional trips as required for members who are eligible for ALTCS.

- B. The Division may authorize additional trips as required for members who are eligible for other ALTCS.

Provider Types and Requirements (Transportation)

Designated District staff will ensure all contractual requirements related to Transportation providers are met before services can be given. Additionally, all providers of ALTCS must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

Service Evaluation (Transportation)

This service shall be reviewed at all Planning Team meetings.

Service Closure (Transportation)

- A. This service shall be terminated when the member no longer requires transportation.
- B. This service shall be terminated if other resources become available.

1280 STATE FUNDED SERVICES

REVISION DATE: 3/2/2015

EFFECTIVE DATE: June 30, 1994

Member and Family Assistance

Member and Family Assistance is flexible support funding intended to enable families to care for children at home and for adult members to live independently in their communities. Member and Family Assistance is based on available funding and is not intended to replace natural or other means of support and assistance. They may be Emergency Support or Ongoing Support as described below.

General Guidelines

All payments from these funds must be made to a vendor, not the family or member unless extenuating circumstances prevent it. For instance, in the case of rent subsidy payable to a family member who is renting to a member all exceptions must be prior approved in writing by a Lieutenant and Program Manager Services that may be purchased with Member and Family Assistance funds include those listed in the Arizona Taxonomy of Services, as well as financial assistance for specific purposes. These services may include:

- A. Automotive repairs (if the vehicle is unable to be driven and would put the member at risk if not repaired);
- B. Clothing;
- C. Corrective lenses;
- D. Dental needs;
- E. Diapers;
- F. Equipment repairs;
- G. Medication;
- H. Moving expenses;
- I. Rent and/or living subsidy;
- J. Transportation; and,
- K. Utilities.

Payments may produce a Federal Income Tax form 1099 that is sent to the recipient of these funds.

Receipts

Receipts must be obtained for all purchases/payments with few exceptions. Exceptions may include ongoing rent so long as an annual rental agreement is on file, showing monthly rent with beginning and end dates. Receipts may also be submitted in the form of a bill or invoice in the case of utility bills or monthly service fees. Receipts are to include the following information:

- A. Vendor name/place of business;
- B. Date of purchase;
- C. Description of item(s) purchased;
- D. Name of Member; and,
- E. Name of Support Coordinator.

All disbursements from Member and Family Assistance funds shall be documented as expended by submission of the original itemized receipt(s) within 30 days. No further funds shall be granted to the vendor until the receipts are submitted, unless approved by the District Program Administrator/Manager or in case of health and safety concerns.

The funds may only be spent for the approved purchase and not for any other items. If there are any excess funds, they are to be returned to the Division.

Emergency Support

Emergency Support provides a one-time payment in emergent or extraordinary circumstances to eligible families on behalf of a member with a developmental disability living in the family home, or (for an adult) in either the family or her/his own home or in rare cases for a member living in a vendor operated setting with prior written approval by the Lieutenant Program Manager for health and safety purposes.

One-time payment amounts typically should not exceed \$500 per member or family. Any amounts over \$300 require Lieutenant Program Manager approval.

Eligible Services

Only authorized services may be purchased with Member and Family Assistance funds. Authorized services are those recommended by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) and approved by the District Program Administrator/District Program Manager or designee. The Division will only approve services that can be purchased at a reasonable cost.

Emergency Support cannot be used to supplement the level of services already furnished to the family or member under Division contracts with service providers.

Emergency Support cannot be used to purchase services otherwise readily available to the family or members who are eligible for Arizona Long Term Care Service (ALTCS). Emergency Support is not available for Licensed Child Developmental or Adult Developmental Homes unless for health or safety matters not funded elsewhere members who have failed to take all reasonable steps to enroll in the ALTCS program are not eligible for Emergency Support.

Other service options must be explored in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and, if appropriate, applications for alternative services or benefits may be made a condition of eligibility to receive Member and Family Assistance. These alternatives might include:

- A. ALTCS;
- B. Income supplements such as Supplemental Security Income, Social Security Survivors Benefits, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Assistance to Needy Families, General Assistance and Emergency Assistance;
- C. Food stamps, Arizona Supplemental Nutrition Program for Women, Infants & Children (WIC) and food banks;
- D. Housing benefits available through Housing and Urban Development;
- E. Vocational Rehabilitation Services and the Job Training Partnership Act Program;
- F. Benefits rendered because of injury to persons or property;
- G. Education programs;
- H. Child support and adoption subsidies;
- I. Arizona Health Care Cost Containment System (AHCCCS), Medicare, Indian Health Services and private health insurance; and,
- J. Supplemental Payments Program and benefits furnished under the Older Americans Act.

Eligibility

All members/families must meet the following criteria to receive Emergency Support:

- A. Enrolled in the Division service system.
- B. Participation in the program by parent, other close relative, legal guardian or by the member. This participation usually takes the form of a co-payment for services.
- C. Require funds for health or safety concerns for which no other funding is available.

Determination of Participation by Responsible Person

The Member and Family Assistance/Emergency Support funds are intended to form a partnership between families and the Division in meeting the needs of children or adults who live at home, or in independent or supported living arrangements not contracted as residential programs by the Division.

Emergency Support is “needs-based” and is not tied to a specific income eligibility level unlike the ALTCS. Families must demonstrate their co-pay participation related to cost for the service, item, or other purchase to be eligible for Emergency Support.

In the case of an adult with a developmental disability living in her/his own home, the member must be able to demonstrate how much income is devoted to shelter and food before Member and Family Assistance/Emergency support payment can be approved. The member must also demonstrate how much income is devoted to an Individual Support Plan Team-approved program before an Emergency Support payment can be provided. The member’s remaining resources are available for personal and incidental expenses. Members with more than \$3,000 in liquid assets (cash) are ineligible for Assistance to Families funds.

The Support Coordinator and member/responsible person shall complete the Member and Family Assistance Request Worksheet and Agreement when requesting participation in this program. The Planning Team shall review these documents and forward them, with a recommendation, to the District Program Manager/Lieutenant Program Manager or designee. The packet must reflect the items or services funded by Emergency Support dollars, the type and amount of support, and the level of participation by the member or family.

Guidelines for Approving Emergency Support

The District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors in evaluating requests for Emergency Support:

- A. Age and/or health status of the parents/family members;
- B. Complexity of the member’s needs the stress that these place on the family, and the family's ability to respond to that stress;
- C. Degree of member or family participation in the cost of services relative to their means;
- D. Degree to which the member is already receiving other Division funded services;
- E. Availability of funding from all sources; and,
- F. Reason for the emergent or extraordinary request.

The District Program Manager/Lieutenant Program Manager should respond to a request for Emergency Support within five (5) working days of the recommendation by the Planning Team.

Payments

Services are authorized and participation/co-payments identified on the Member and Family Assistance Worksheet and Agreement. If approved, the payment will go directly to the vendor identified by the member or family.

Waivers

The District Program Administrator/Lieutenant Program Manager must approve any waivers for procedures or family participation. The waiver is only allowed if the goals and intent of the program are otherwise met.

The member, family, or Support Coordinator is permitted to initiate a written request for a waiver. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan Team may also initiate a written waiver request. The request must identify the specific requirements to be waived. The Lieutenant Program Manager/ Program Manager will determine whether approval of the requested waiver will enable the goals and intent of the program to be met. The Lieutenant Program Manager/District Program Manager will respond to the initiator of the request, in writing, within ten working days. Payments to other than a vendor must also be approved by the Division's Business Operations Administrator.

Ongoing Support

Ongoing Support is an on-going payment to a vendor intended to support the family's effort to maintain its family member with a disability in the family home, thereby preventing out-of-home placement; or to support an adult to live in their own home, thereby preventing placement in more restrictive settings. Payments are made directly to the vendor identified by the member or family or in the case of members living in Individually Designed Living Arrangements (IDLA), payments may be made to the provider who will make payments to landlords, utilities, and other living cost on behalf of a member.

When Ongoing Support payments are made to a provider for members living in an IDLA, the provider is required to maintain a detailed expenditures log for each member identifying all expenditures on behalf of the member, including:

- A. Date;
- B. Vendor;
- C. Purchase/payment detail;
- D. Amount; and,
- E. Declining balance with all supporting documentation and receipts attached.

This expenditure log must be made available to the Division and/or the guardian upon request at any time.

Eligible Services – Ongoing Support

The Division will only approve services that can be purchased at a reasonable cost and that advance/meet the goals of the Member and Family Assistance program and the Division.

Ineligible Services

Ongoing Support cannot be used for the following:

- A. Services available under ALTCS;
- B. Members who live in Developmental Homes, Group Homes, Intermediate Care Facilities for Persons with an Intellectual Disability, Nursing Facilities, or Assisted Living Centers;
- C. Members who have failed to take all reasonable steps to enroll in the ALTCS; and,
- D. Families with income that exceeds 300% of the federal poverty level.

Alternative Options

The Individual Support Plan/Individual Family Services Plan/Person Centered Plan Team members must explore other service options and, if appropriate, applications for alternative services or benefits may be made as a condition of eligibility to receive Ongoing Support. These alternatives include:

- A. The ALTCS;
- B. Income supplements such as Supplemental Security Income, Social Security, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Aid to Needy Families, General Assistance, and Emergency Assistance;
- C. Food stamps, WIC, and food banks;
- D. Housing benefits available through Housing and Urban Development and other housing assistance;
- E. Vocational Rehabilitation Services and assistance through the Job Training Partnership Act;
- F. Education programs;
- G. Child support and adoption subsidy;
- H. AHCCCS, Medicare, Indian Health Services, and private health insurance;
- I. Supplemental Payment Program and benefits furnished under the Older Americans Act; and,
- J. Other community, and religious based services, and programs.

Eligibility

All members/families must meet the following criteria during any month wherein Ongoing Support is received:

- A. Enrolled in the Division;
- B. Participation in the program by parent, other close relative, legal guardian, or by the member. This participation usually takes the form of a co-payment for goods or services, although it may involve participation in the form of a contribution of labor. Members in an IDLA with no familial supports or source of other income or require extensive supports and medically or behaviorally unable to participate in their own service delivery may be exempt from this requirement.

Determination of Participation by Responsible Person

Whenever possible, families or members must demonstrate their participation in the cost of service, item or other purchase to be eligible for Community Living Support.

The member must be able to demonstrate how much income is devoted to shelter, food, and program cost. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team must approve the programs referenced. The member's remaining resources are available for personal and incidental expenses. Members with more than \$1,500 cash or \$2,000 in liquid assets are ineligible for Ongoing Support. The member's Ongoing Support payment will be interrupted or terminated until they can demonstrate the need for continued or renewed support.

The Support Coordinator and the Planning Team shall review these documents, the family's resources, and any funds the member may have:

- A. Savings and checking accounts;
- B. Bonds;
- C. Trust funds;
- D. Tort-feasor (civil judgments) funds;
- E. Annuities;
- F. Estates;
- G. Wages;
- H. Benefits;
- I. Child support payments; and,
- J. Other financial resources and income.

The Support Coordinator shall then submit the request, including the items or services to be purchased and amount of family or member participation.

Guidelines for Approving Ongoing Support

In evaluating requests for Ongoing Support, the District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors:

- A. Availability of funding;
- B. The likelihood that Ongoing Support will enhance the family's integrity, prevent the need for residential placement, avoid a more restrictive placement, or foster a smooth transition to more independent living for an adult with a developmental disability;
- C. The age and/or health status of the parents/family members;
- D. The complexity of the member's needs, the stress that these place on the family and the family's ability to respond;
- E. The degree of member or family participation in the cost of services relative to their means;
- F. The anticipated duration of the need for service;
- G. The degree to which the family/member is already receiving other Division funded services; and,
- H. Other resources that may be available to the member/family.

The District Program Manager/Lieutenant Program Manager shall approve the response to a request for Ongoing Support funds within 14 working days of the recommendation by the Support Coordinator and Planning Team.

Payments

Authorized services, vendor payments and co-payments are identified on the Member and Family Assistance Request Worksheet and Agreement. They must be ongoing payments.

The Ongoing Support Payments may only be made when the initial/prior payment has been verified as expended for the authorized purpose (receipts, or when not available, then via a written, signed statement by the recipient member or family, or upon receipt of a bill, rental agreement, invoice, or quote from a vendor). In some cases, receipts totaling less than the advanced sum will result in a reduction of the subsequent payment of the Ongoing Support award and will require a return of the unspent supports.

Ongoing supports for food for members living in an Individually Designed Living Arrangement do not require an automatic reduction in the ongoing monthly support unless an ongoing trend in unspent Support is demonstrated, in which case the Support Coordinator shall make a re-determination regarding on the level on Ongoing Support required. Receipts exceeding the authorized amount will not result in an increase in the

subsequent payment. In-kind contributions including volunteer time must be documented in writing and submitted along with the receipts.

Waivers

Waivers of any Ongoing Support procedures, including member or family participation requirements, may be granted by the District Program Manager/Lieutenant Program Manager, if the goals and intent of the program are otherwise met.

The member, Support Coordinator, or Planning Team may initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Manager/Lieutenant Program Manager will determine whether approval of the waiver request will enable the goals and intent of the program to be met. The District Program Manager/Lieutenant Program Manager will respond to the initiator of the request, in writing within ten working of receipt of the request.

Exhibit 1240A-1 ATTENDANT CARE SUPERVISION REQUIREMENTS AGE 17 AND UNDER

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to meet medical necessity for **general supervision** for children age 17 and under as part of the Attendant Care service.

Age 17 and under: A child must meet the criteria indicated in one of the four categories outlined below:

A. Unsafe Behaviors

1. Documentation of behaviors placing the child at risk of injury to self or others; **AND**,
2. Documentation that the child is receiving or pursuing services through a behavioral health agency/professional; **or**,
3. Documentation of behaviors placing the child at risk of injury to self or others; **AND**,
4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical

Documentation is required from a medical professional describing a severe medical need or physical condition that would place the child at risk if left alone.

C. Confused/Disoriented

Documentation indicating a loss of skills (e.g., due to accident or injury) that are unlikely to be regained.

D. Wandering risk (age 13 - 17 only)

1. Documentation of the child leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; **AND**,
2. The youth is at risk to self or others when alone in the community or may be unable to return safely.

When a child age 17 and under meets one of the criteria outlined above, **general supervision** is then based on age criteria. The requirements outlined below may be waived with District Program Manager approval.

For children age 12 and under, general supervision may be provided when **all** of the following are met:

- A. The child cannot attend a typical day care center because
 - 1. The child's health and safety would be at risk; **OR**,
 - 2. The health and safety of others will be at risk; **OR**,
 - 3. A fundamental alteration of a day care center would be required. This requires documentation from the day care center;

AND,
- B. Child care in a private home or a before/after school program offered by the school/local city or county is not available or cannot meet the child's needs;

AND,
- C. The parent, guardian, or other adult is not in the home;

AND,
- D. Division funded summer or after school program is not available or cannot meet the child's needs (Only applies to age 3 and above.)

For children age 13- 17 **general supervision** may be provided when **all** of the following are met:

- A. A Division funded program is not available or has been considered and is not appropriate;

AND,
- B. The youth receives enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP);

AND,
- C. The parent, guardian or other adult is not in the home;

AND,
- D. The youth has received, is receiving or will receive Habilitation to minimize the need for supervision in the future, if a wandering risk or has unsafe behaviors.

Exhibit 1240A-2 ATTENDANT CARE SUPERVISION REQUIREMENTS AGE 18 AND ABOVE

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to qualify for general supervision for adults age 18 and above as part of the Attendant Care service.

Age 18 and above: An adult must meet one of the criteria outlined below:

A. Unsafe behaviors

1. Documentation that behaviors place the adult at risk of injury to self or others; and,
2. Documentation that the person is receiving or pursuing services through a behavioral health agency/professional;
3. Documentation that behaviors placing the adult at risk of injury to self or others; or
4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical

Documentation is required from a medical professional describing a severe medical need or physical condition that would place the adult at risk if left alone.

C. Wandering risk

1. Documentation of the adult leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; and,
2. The adult is at risk when alone in the community and may be unable to return safely.

D. Confused/disoriented

1. Documentation of the presence of confusion or disorientation (prior to being diagnosed with dementia); or,
2. Documentation indicating a loss of skills (e.g., due to accident or injury) and are unlikely to be regained.

E. Unable to call for help even with a lifeline.

Documentation is available in the member's file that the adult is unable to use a telephone or press a button to alert the lifeline system.

When an adult 18 years of age and older meets one of the criteria outlined above, supervision is then based on the following age criteria. The requirements outlined below may be waived with District Program Manager approval.

For adults age 18 and above supervision may be provided when the first criteria and the others (if applicable) are met:

- A. A Division funded employment/day program is not available or has been considered and not appropriate.
- B. If still in school, the adult must receive enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP).
- C. If appropriate, an adult who has an identified wandering risk or has unsafe behaviors must have received, is receiving or will receive habilitation to minimize the need for supervision in the future.

Exhibit 1240A-3 ATTENDANT CARE SUPERVISION DOCUMENTATION REQUIREMENTS

REVISION: 2/26/2016

EFFECTIVE DATE: March 1, 2014

Overview

Documents that may provide justification of medical necessity for supervision include, but are not limited to the following:

- A. Individual Support Plan;
- B. Individualized Education Program (IEP);
- C. Multi-Disciplinary Education Team (MET);
- D. Medical Documentation;
- E. Psychiatric/Psychological Evaluation;
- F. Clinical Notes;
- G. Incident Reports;
- H. Pre-Admission Screening (PAS);
- I. Police Reports;
- J. Inventory for Client and Agency Planning (ICAP); and,
- K. Adaptive Mini-Mental (Pre-Dementia Screening Tool).

Exhibit 1240G-1 SKILLED NURSING MATRIX

REVISION DATE: 1/31/2014

EFFECTIVE DATE: August 30, 2013

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Anticoagulant Therapy	Medications used to make the blood less likely to clot or form scabs.	Assessment and monitoring for unstable anticoagulant therapy.
Apical Pulse Check	Use of a stethoscope to listen to the heart beat at the level of the heart.	Listening to heart beat on chest for full minute.
Bi-level positive airway pressure (BiPAP)	A machine that helps an individual breathe.	Turning on and off, changing settings, respiratory assessment, circuit changes.
Blood Pressure Checks	Assessment of Blood Pressure.	Blood pressure monitoring and treatment when it is too high or too low.
Chest percussion therapy (CPT)	Therapy by clapping on the chest either manually or with a machine.	Application of the therapy techniques and assessment of effectiveness, respiratory assessment.
Complex wound care	Assessment and treatment of wound.	Assessment and treatment of wound, including but not limited to wound cleaning and bandage changes.
Complex/Unstable Seizure Disorder	A change in the way a person acts or moves that is not normal due to a brain problem.	Neurological assessment and emergency medical intervention for unstable seizure activity.
Coughalator/cough assist device	A machine that causes the member to cough.	Application of machine and assessment of effectiveness of machine; respiratory assessment.

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Dialysis (occurring at home)	Cleaning of blood through a machine or tube.	Assessment and monitoring; starting and stopping of the treatment.
Extremity edema checks when ordered by a physician	Assessment of extra fluid buildup in the extremities.	Checking for fluid in the legs or arms; assessment.
GJ Tube Gastrostomy/Jejunostomy	A feeding tube into the gastric (stomach) continuing to the Jejunum (small intestine).	Insertion of liquid food, water and/or medication into the tube.
Injections	Medication given with a needle.	Administering medication with a needle.
Insulin Administration	Medications given with a needle to treat diabetes.	Administering insulin with a needle.
Intermittent partial pressure breathing (IPPB)	A machine to assist with breathing all the time.	Monitoring effectiveness of machine, changing settings on machine as ordered, respiratory assessment and intervention, circuit changes.
Intravenous (IV) Therapy (For individuals living at home)	Administration of fluids and medications into the venous blood supply.	Administering medications through an IV into the blood and any dressing changes needed.
J-Tube (Jejunum-tube)	A feeding tube through the Jejunum (small intestine).	Insertion of liquid food, water and/or medication into the tube.
Nasogastric enteral feeding (NG tube)	Liquid food and water fed through a tube from the nose into the stomach.	Checking tube placement; start feeding; stop feeding.
Nephrostomy	Surgically placed tubes used to flush fluid to clean the kidney(s).	Flushing fluid into tubes that cleans the kidney(s).
Ostomy irrigation	Flushing of an opening into the body with fluid.	Cleaning out the organ with fluid.

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Oxygen Titration	Giving oxygen at an amount that changes dependent on the person's blood oxygen level.	Changing the level of oxygen administration based on pulse oximeter readings.
Postural drainage	A treatment to clear the lungs by moving the body in a downward position.	Assessment and draining the lungs of fluids.
Pressure Ulcer	An area of the skin that breaks down when something keeps rubbing or pressing against the skin.	Assessment and monitoring of the care and healing of the pressure ulcer.
Pulse Oximeter	A machine that measures oxygen levels in the blood.	Monitoring the amount of oxygen in the body.
Sleep Apnea	The temporary stoppage of breathing during sleep.	BiPAP machine or Vent used to treat the condition, respiratory assessment (the assessment for Apneic episodes).
Small Volume Nebulizer (SVN) (varied or unscheduled)	Medications given at varied times using a small-volume nebulizer, a device that holds liquid medicine which is then turned into a fine mist.	Assessment of needed time for medicated breathing treatments.
Sputum sample	Chest fluid sample test.	Collection of fluid from chest.
Suctioning (tracheal or deep through the nose or mouth)	Use of a tube to suction out the throat and lungs through a tube in the throat or deep into the mouth.	Inserting tube into the throat and/or lungs through the mouth or the nose to get fluid out.
Tracheotomy	A surgery to make an opening through the neck into the windpipe to allow for breathing.	All tracheotomy management and care.



Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Urinary Catheter	A tube into the bladder to drain out urine.	Insertion of a tube into the bladder to drain out urine.
Ventilator	A machine that provides breathing support continuously.	All ventilator management and care.