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600 SERVICES

601 Overview

This chapter describes each long term and acute care service provided by the Division. It further provides a description of each service including who, what, where, how and when of the service provision, the provider type and training required, and the service limitations and exclusions (non-Long Term Care Services covered services are available based upon the availability of state funds). It defines the delivery system for acute care services.

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.

601.1 Family Members As Paid Providers

In some situations, family members may be paid to provide certain services. Immediate relatives permitted to provide service include the following:

- A. Natural Child
- B. Natural Sibling
- C. Adoptive Child
- D. Adoptive Sibling
- E. Stepchild or Stepsibling
- F. Father-in-Law, Mother-in-Law, Son-in-Law, Daughter-in-Law, Sister-in-Law, Brother-in-Law

- G. Grandparent or Grandchild
- H. Spouse of Grandparent or Grandchild

Immediate relatives not permitted to provide services for children under age 18 include:

- A. Natural Parent
- B. Adoptive Parent
- C. Step Parent

Certain requirements are specific to family members who may be paid to provide supports to their family member with a developmental disability. They include:

- A. Parent/Step Parents may only be paid for an adult child (over age 18). Other family members of an adult or minor who meet certification requirements may be paid to provide services.
- B. A spouse of a person with a developmental disability may not be paid to provide services to their spouse. (See Attendant Care section for exception.)
- C. The Planning Team must determine the type and amount of services the person needs within their home environment. This determination is based on assessed need as well as the availability of natural and community resources.
- D. Family members cannot be paid for skilled care during the provision of services such as Attendant Care or habilitation (skilled care includes but is not limited to: G-tube insertion and feedings, catheter replacement, respiratory treatment such as Small Volume Nebulizers or suctioning tracheostomy care. (See Appendix D – Skilled Nursing Matrix.).
- E. A single family member who is an individual independent provider may not be paid to provide more than 40 hours of any combination of service per week. This maximum of 40 hours per week does not limit another family member from providing services. For example, an adoptive sibling may provide 38 hours of services and the grandparent may provide another 12 hours of service.
- F. Family members must comply with all requirements in their contract in addition to all policies, procedures, laws and rules.
- G. Primary caregivers/parents may not be paid to provide Respite.
- H. Services shall not replace care provided by the person's natural support system.
- I. Family members shall participate in and cooperate with ongoing monitoring requirements by the Division.

- J. Qualified family members may become certified home and community based services providers by meeting the certification requirements, as applicable.
- K. When a family member requests to become the provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

Home and Community Based Service Delivery

Member directed service options allow members to have more control and flexibility over how some of their services are provided. The options are not a new service, but rather a way of providing services which offers the member the ability to play a more active role in directing their own care. Member directed service options are available to Arizona Long Term Care System (ALTCS) members who live in their own home.

Traditional

Traditional is a way of providing Home and Community Based services which offers members the ability to select a Qualified Vendor.

Agency with Choice

Agency with Choice is a way of providing Attendant Care (ATC), Homemaker (HSK) or Habilitation (HAH/HAI) services which offers members the ability to play a more active role in directing their own care. The Agency with Choice service option allows ALTCS members living at home to enter into a co-employment relationship with the provider agency. This gives the member more control over assigning duties and schedules for the caregiver but leaves the hiring, firing, and minimal training requirements as the responsibility of the provider agency.

If a member is unable to fulfill the co-employment roles and responsibilities for the above listed services on their own, an Individual Representative may be appointed to assist them in directing their care. If a member has a legal guardian, that guardian automatically serves in the capacity of an Individual Representative. The role of an Individual Representative is to act on the member's behalf in choosing and directing care, including representing the member during the service planning process and approving the service plan. Arizona Administrative Code Title 9, Chapter 28, Section 509 (A.A.C. R9-28-509) and Section 1915 (k) of the Social Security Act prohibit an Individual Representative from serving as a member's paid Direct Care Worker.

Individual Independent Providers

Individual Independent Providers is a way of providing Attendant Care (ATC), Homemaker (HSK), Respite and Habilitation (HAH/HAI) services which offers members and their families the ability to direct their care. This gives the member control over assigning duties and schedules for the direct care worker including hiring, firing, and minimal training requirements. The member/responsible person

must enroll with the Division's Fiscal Intermediary agency as the employer of record. The member or responsible person can change individual independent providers at any time. This method of service delivery mainly differs from Traditional and Agency with Choice in that the member does not have to choose a direct care worker employed by a Qualified Vendor to deliver these services.

602 Services

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.

Although the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan 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 least costly 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 etc.

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
- D. The Division Service Specifications.

602.1 Assisted Living Centers

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:

"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.

"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.

"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.

Considerations

To ensure the appropriateness of a placement in a Center, 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 Center best meets the needs, desires, and capabilities of the member.
- C. Alternate placements were considered and the reason why they were not appropriate. Center 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 center.
- F. The member will be placed with a similar age group as the other members living in the Center 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 Center/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 Center 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.
- 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 Centers, 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.
- M. Monthly newsletter or calendar of events.

Exclusions

Under no circumstance will an Assisted Living Center /Assisted Living Facility be used for Respite.

602.2 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 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.
- 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.
- 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 member's 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 (ICF), 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 policy.
- 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.
- 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.
 - i. When used as a substitute, Attendant Care shall be used only until an appropriate service is available.
 - ii. 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.
 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.)
 - 9. Shopping for a child living in the family home.
- C. The Division will not authorize Attendant Care when the only tasks identified are cleaning, shopping and laundry. (See Homemaker section in this chapter.)

602.3 Day Treatment and Training

602.3.1 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:

- A. Increase or maintain the self-sufficiency of eligible members.
- B. Improve emotional and mental well-being.
- C. Enable eligible members and their families to acquire knowledge and skills.
- D. Ensure the availability to eligible members of information about and access to human services and community resources.
- E. Develop positive relationships with and support for families.
- F. Encourage family and member participation in areas of the program.
- G. Recognize and acknowledge that the members (and families, if guardians) are the main decision makers in the delivery of service.
- H. Ensure that programs optimize the health and physical well-being of the members served.

- I. Provide opportunities for members to participate in meaningful community activities.
- J. For early intervention, to partner with families to support the parent-child relationship as the primary relationship in the context of naturally occurring routines and activities the family identifies as priorities.
- K. Produce outcomes of increased individual skill development toward Individual Support Plan/Individualized Family Services Plan/Person Centered Plan member and family goals.
- L. Assist members in achieving and maintaining a quality of life that promotes the member's vision of the future.

602.3.2 Service Settings (Day Treatment and Training)

Early intervention services for children age birth to 36 months of age and their families are provided in natural environments including the home and community settings in which children without disabilities participate. All other Day Treatment and Training may be provided in any setting and including during the school year and summer vacation. Day Treatment and Training may not be provided in an ICF/IID, child or adult developmental home or group home.

602.3.3 Service Requirements (Day Treatment and Training)

Before Day Treatment and Training can be authorized, the following requirements must be met:

- A. The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) must identify needs and outcomes consistent with the service description and setting.
- B. Training and instruction must be pertinent to the present developmental, physical, mental and/or sensory abilities of the member.

602.3.4 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:

- A. Birth - 36 Months of Age.
Day Treatment and Training is appropriate when the family's concerns, priorities, and resources identify that the developmental needs of their child would best be met by these supports.
- B. Age 36 Months - 5 Years of Age.

Generally children of this age range will receive this service from public schools in accordance with Part B of Public Law 105-17, (www.gpoaccess.gov/plaws/) however, the provision of Day Treatment and Training by the Division may be appropriate, in some instances, if all of the following conditions are met:

1. The Planning Document identifies needs above and beyond those identified in the Individualized Educational Plan.
2. The additional hours of Day Treatment and Training would be 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.
3. The child's developmental needs can best be met in a group setting.
4. Family and other community resources are not available to meet the need.
5. No other service is more appropriate.

C. Age 5 - 12 Years of Age.

Generally, children with developmental disabilities will have their need for this service met by the public school system, therefore, most children will not need nor receive Day Treatment and Training during periods of time they are eligible for public education services.

Arizona Health Care Cost Containment System (AHCCCS) does not pay for child care or Respite as an alternative to Day Treatment and Training services for children 5 to 12 years of age. The provision of Day Treatment and Training by the Division may be considered for this age group if all the requirements for the 3 - 5 years age group are met and if the child needs to develop appropriate social and behavioral interaction skills and opportunities to integrate with non-disabled peers. If the Division considers Day Treatment and Training services for children 5 - 12 years of age, habilitation goals and objectives must be established and documented in the Individualized Family Services Plan/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 the 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.

D. Age 13 - Graduation from High School (18 - 22 Years of Age.)

Generally, members with developmental disabilities will have their need for this service met by the public school system, therefore, most

members will not need nor receive Day Treatment and Training during periods of time they are eligible for public education services. The provision of Day Treatment and Training by the Division may be considered for this age group if all the requirements for the 3 - 5 years age group are met. In addition, the Support Coordinator must determine that community resources are unavailable to meet skills identified in the Service Description and Goals Section, 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.

E. Adults

Day Treatment and Training should enable members to increase their range of independent functioning and to refine their personal living skills. The service shall be age appropriate.

Members participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

602.3.5 Exclusions (Day Treatment and Training)

Exclusions include to the provision of Day Treatment and Training shall not:

- A. Substitute for Respite or day care.
- B. Be used in place of regular educational programs as provided under Public Law 105-17. (www.gpoaccess.gov/plaws/)
- C. Be used to provide other related services that have been determined in the Individualized Education Plan to be educationally necessary.
- D. Be used when another service, such as an employment service, is more appropriate.
- E. Include wage-related activities that would entitle the member to wages.

602.3.6 Service Provision Guidelines (Day Treatment and Training)

Utilization of Day Treatment and Training will be in accordance with the Individual Support Plan/Person Centered Plan (Planning Documents).

602.3.7 Provider Types and Requirements (Day Treatment and Training)

Designated District staff will ensure that all contractual requirements related to Day Treatment and Training providers are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by The

Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.3.8 Service Evaluation (Day Treatment and Training)

The Support Coordinator must continually assess the quality of services provided to members with developmental disabilities as defined in the mission statement. In addition:

- 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. On a monthly basis, the Support Coordinator must review these reports for progress toward outcomes. If there is no progress in the time period specified, the member with their 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.
- B. The Support Coordinator must perform a review of the Planning Documents as noted in this policy manual.
- C. The provider must maintain a monthly activity schedule based on the goals and preferences of the persons' supported.
- D. Materials, supplies and equipment used to deliver Day Treatment and Training must be furnished by the program and meet the needs of the member and be age appropriate.

602.3.9 Service Closure (Day Treatment and Training)

Service closure should occur in the following situations:

- A. Based on the member's progress, the Planning Documents should determine when goals have been met and the service terminated.
- B. The member/responsible person decline the service.
- C. The member moves out of state.
- D. The member transitions to another age/skill appropriate service or program.
- E. The member/responsible person/family can now meet the needs the service addressed, as identified in the Planning Documents.

A Notice of Intended Action must be sent in accordance with the processes defined in this manual.

602.4 Employment Related Programs

602.4.1 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.

- A. Individual Supported Employment provides job coaching contacts at an integrated community job site with the employed member and/or employer. This service is to help ensure that the member maintains employment. Individual Supported Employment may also include job search services if these services are not available through Vocation Rehabilitation.

Members receiving this service must not be a part of an enclave or work crew and must be paid by the employer. Individual Supported Employment is a time-limited service shall be provided on a member basis and can be used for members who are self-employed.

- B. 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.
- C. Center Based Employment is a service that provides members a healthy, safe 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. The service goal is to provide members with gainful, productive, and remunerative work.
- D. Transition to Employment is a service that provides individualized and time-limited instruction, training and supports to help the member achieve the employment-related outcomes in the member's planning document. Through the use of a Division approved curriculum, including unpaid work exploration and job shadowing opportunities, the provider will assist the member to develop positive work habits, attitudes, skills, and work etiquette. Members receiving this service are expected to gain and demonstrate job readiness skills and be referred for integrated and competitive employment upon completion.
- E. Employment Support Aide services provide members with the one-to-one supports needed to enable them to remain in their employment. These supports can include personal care services, behavioral intervention, and/or "job follow along" supports, and may be provided in any of the above service settings, as well as a stand-alone service.

- F. Split Programming may be appropriate for members who desire to participate in multiple employment supports and services. These services are billed hourly and based 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.

602.4.2 Transportation Services for Employment Related Programs

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.

602.4.3 Target Populations (Employment Supports and Services)

Members who may benefit from supported employment as determined by the Planning Team (Individual Support Plan/Person Centered Plan team).

The Individual Support Plan/Person Centered Plan meetings and monthly progress reports from providers may be used as a means to identify the need for employment services. Participation in Individual Employment 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.

The member with their Planning Team (Individual Support Plan/Person Centered Plan team) identifies the member's desires and dreams, employment goal and prior work history. In addition the role of the Planning Teams includes a description regarding the level of support needed and documentation of these needs (including transportation) on the Individual Support Plan/Person Centered Plan.

Employment Supports and Services are available to members who are eligible for Arizona Long Term Care Services based on assessed need, and to State-funded only members based on assessed need and availability of funding.

602.4.4 Service Requirements and Referral Process (Employment Supports and Services)

The Support Coordinator completes a Request for Employment Supports and Services packet when the Planning Team determines that a member may benefit from an employment related service.

This packet is then submitted to the Employment Program Specialist. The service code "VRI" shall be entered into the Focus system as part of the service plan and waiting list data as a current need. The outcome/objective shall also be added to the Individual Support Plan. The Employment Program Specialist reviews the

referral packet and determines if the member will go directly to Center-Based Employment or if the packet will be sent to Rehabilitation Services Administration/Vocational Rehabilitation Program.

Members/families that are referred to the Vocational Rehabilitation Program receive an orientation and complete an application. The Vocational Rehabilitation Program then determines eligibility for services. If eligible, services will be provided by the Vocational Rehabilitation Program.

The Support Coordinator should then take the VRI service off the wait list and open it as an indirect service.

If ineligible, the Vocational Rehabilitation Program will close the case and the member will be and referred back to the Division. At this point, the member with their Individual Support Plan team, including the District Employment Program Specialist, will reconvene to determine how best to meet the member's need for an employment related service. The VRI code should be removed from the wait list.

602.4.5 Service Provision Guidelines (Employment Supports and Services)

Transition from the Vocational Rehabilitation Program to the Division of Developmental Disabilities

The Vocational Rehabilitation Program counselor notifies the Support Coordinator of upcoming transitions. The Support Coordinator then notifies the Employment Program Specialist of anticipated transitions. The Support Coordinator contacts the member/family and offers a list of Qualified Vendors. The member/family selects a Qualified Vendor. The Qualified Vendor is then notified and given an opportunity to accept or decline service provision.

When a Qualified Vendor is identified, a transition meeting with the member/family, the Vocational Rehabilitation counselor, the Support Coordinator, and Qualified Vendor is held to review the employment placement. This transition meeting is also used to review progress and services still needed by the member/family. The needed supports for the member's success and the date of transfer are also determined at the Vocational Rehabilitation transition meeting.

Authorization for Employment Supports and Services

The authorization process for Employment Supports and Services starts with the Support Coordinator adding the appropriate code to the Service Plan. The Support Coordinator then submits the authorization request to the District designee. The District designee generates authorization for services.

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 will require a new written authorization.

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 and notification of the District Employment Program Specialist. Progressive moves within Employment Supports and Services require a Request for Employment Supports and Services Packet to be completed.

Tracking and Reporting (Employment Supports and Services)

The Qualified Vendor is required to submit individualized monthly progress reports on Division forms to the Support Coordinator. The Support Coordinator ensures that Qualified Vendors submit required reports and will address reported issues.

The Support Coordinator will contact the District Employment Program Specialists if concerns cannot be resolved. The Qualified Vendor will submit a report on Division forms every six months to the Employment Program Specialist.

Monitoring and Technical Support (Employment Supports and Services)

At a minimum, the District Employment Program Specialist will perform an annual on-site Quality Assurance Review of all Qualified Vendors who provide Employment Supports and Services. The Employment Program Specialist will also review the Qualified Vendors' "six month" reports, and provide on-site visits and technical support as needed.

602.5 Habilitation

Description (Habilitation)

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

Barring exclusions noted in this section, based on member and family priorities Habilitation may be provided to:

- A. Increase or maintain independence and socialization skills.
- B. Increase or maintain safety and community skills.
- C. Increase or maintain the member's health and safety.
- D. Provide training in:
 1. Essential activities required to meet personal and physical needs.
 2. Alternative and/or adaptive communication skills.

3. Self-help/living skills.
 - E. Develop the member's support system to reduce the need for paid services.
 - F. Help family members learn how to teach the member a new skill.
 - G. When this service is authorized in conjunction with a Habilitation Behavioral Masters/Bachelors program, the Habilitation Hourly provider will follow the plan developed by the Habilitation Behavioral Masters/Bachelors provider.

Considerations (Habilitation)

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

- A. Existing community support systems have been exhausted and no other service is more appropriate.
- B. The member's documented needs cannot be met by the member's support system, employment program or a day program.
- C. Habilitation can support therapy home program strategies.

Settings (Habilitation)

Habilitation Services may be provided:

- A. Hourly or daily in the member's own home.
- B. Hourly in the home the member shares with the family.
- C. Daily in a group home.
- D. Hourly in a Child Protective Services licensed foster home.
- E. Daily in a developmental home.
- F. 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).

Exclusions (Habilitation)

Exclusions to the authorization of Habilitation Services include, but are not limited to:

- A. Habilitation shall not substitute for Respite or day care.
- B. Habilitation shall not be used in place of regular educational programs as provided under Public Law 108-446 IDEA Part B.
- C. Habilitation shall not substitute for funded or private pay day programs.

- D. Habilitation shall not be used when another service is more appropriate.
- E. Hourly Habilitation shall not be authorized when Daily Habilitation is authorized.
- F. Habilitation shall not be provided in private or public schools during school hours or in transit to schools.
- G. Habilitation shall not be provided in a provider's residence unless the residence is also the home of the member receiving the service.
- H. Hourly Habilitation shall not be provided in a Qualified Vendor owned or leased service site.
- I. Hourly habilitation shall not be offered in vendor supported Child Development Foster Homes or Adult Developmental Homes unless the following are met:
 - 1. There is a specific issue, problem or concern that is believed to be temporary or short term.
 - 2. The Planning Document must outline specific, time limited goals/outcomes regarding the service to be provided.
 - 3. Monthly progress reports validate continuing the service.

602.6 Home Health Aide

602.6.1 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.

602.6.2 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.

602.6.3 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.

602.6.4 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.

602.6.5 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.
- B. Home Health Aides shall not provide skilled nursing services.

602.6.6 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.

602.6.7 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 Long Term Care Services must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.6.8 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.

602.6.9 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).
- E. The member/responsible person 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 this policy manual.

602.7 Home Nursing

602.7.1 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 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 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.
- B. Improve or maintain the physical well-being of eligible members.

602.7.2 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.

602.7.3 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.
 - 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.
 - 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).

602.7.4 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.

602.7.5 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.
- D. Nurses shall not provide direct supervision of non-licensed persons engaged in service provision.

602.7.6 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.

602.7.7 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 Long Term Care Services must be certified by the Division and registered with the AHCCCS prior to service initiation.

602.7.8 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.

602.7.9 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.

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.8 Hospice

602.8.1 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 should 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.
- 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.
 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.

602.9 Homemaker (Housekeeping)

602.9.1 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.

602.9.2 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.

602.9.3 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.
 - 9. Routine maintenance of household appliances.
- C. Washing, drying and folding the member's laundry (ironing only if the member's clothes cannot be worn otherwise).
- D. Shopping for and storing household supplies and medicines.

- E. Unusual circumstances may require the following tasks be performed:
1. Tasks performed to attain safe living conditions:
 - i. Heavy cleaning such as washing walls or ceilings.
 - ii. 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:
 - i. Hauling water for household use.
 - ii. Gathering and hauling firewood for household heating or cooking including sawing logs and chopping wood into usable sizes.
 - iii. Caring for livestock used for consumption including feeding, watering and milking.
 3. Provide or insure nutritional maintenance for the member by planning, shopping, storing and cooking foods for nutritious meals.

602.9.4 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 Long Term Care Services 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 are available and not supplant them. In addition to the guidelines found in section 602, 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.
- 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.

602.9.5 Exclusions (Homemaker)

The following exclusions apply to the provision of Homemaker:

- A. Homemaker is to be performed only for the member's areas of the home or common areas of the home used by the member, i.e., parents' or sibling's 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.
 - 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.

602.9.6 Service Provision Guidelines (Homemaker)

Typical utilization of Homemaker would be 2 - 4 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.

- 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.

602.9.7 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 Long Term Care Services must be certified by the Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.9.8 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.

602.9.9 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 Long Term Care Services (refer to the Supplemental Payment Program).
- E. The member moves to a residential or institutional setting.
- 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.

602.9.10 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.

602.10 Intermediate Care Facilities for Persons with an Intellectual Disability

602.10.1 Service Description and Goals (Intermediate Care Facility for Individuals with an Intellectual Disability)

This service provides health and habilitative services to members with developmental disabilities.

The goal of this service is to provide an environment in which the programmatic and habilitative needs of eligible persons are met through an active treatment process.

A continuous active treatment program includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the member to function with as much self-determination as possible; and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

602.10.2 Service Settings (Intermediate Care Facility for Individuals with an Intellectual Disability)

Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) shall only include the Arizona training program facilities, a State owned and operated service center, State owned or operated residential settings or existing licensed facilities operated by the State or under contract with the Department on or before July 1, 1988.

A.R.S. § 36-2939(B)(1) azleg.gov/ArizonaRevisedStatutes.asp

602.10.3 Service/Provider Requirements (Intermediate Care Facility for Individuals with an Intellectual Disability)

- A. The ICF/IID shall be reviewed annually by the Department of Health Services and certified by Arizona Health Care Cost Containment System (AHCCCS) or pursuing certification.

- B. The ICF/IID shall be licensed, certified and monitored in accordance with A.R.S. § 36-591(G). azleg.gov/ArizonaRevisedStatutes.asp
- C. The ICF/IID shall comply with the conditions set forth in Chapter 42 of the Code of Federal Regulations. www.gpoaccess.gov/cfr/
- D. The ICF/IID shall comply with A.A.C. R6-6-901 through R6-6-910 Managing Inappropriate Behaviors. azsos.gov/public_services/rules.htm
- E. A Cost Effectiveness Study (CES) shall be completed prior to admission or discharge from an ICF/IID.

602.10.4 Target Population (Intermediate Care Facility for Individuals with an Intellectual Disability)

- A. Health Care Services requires review and revision of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) prior to any permanent/temporary admission to a private ICF/IID. The Support Coordinator shall forward the Planning Documents to Health Care Services (HCS). The written authorization of the Assistant Director shall be required prior to placement.
- B. Prior to considering a permanent/temporary placement in a state operated ICF/IID, the Division Support Coordinator shall exhaust all other placement options (including private ICF/IID and written approval by the Assistant Director is required).

602.10.5 Exclusions (Intermediate Care Facility for Individuals with an Intellectual Disability)

ICF/IID placements shall not be made when appropriate, cost effective services are available in the community.

Therapeutic leave shall not exceed 9 days and bed hold days shall not exceed 12 days per calendar year.

602.10.6 Service Provision Guidelines (Intermediate Care Facility for Individuals with an Intellectual Disability)

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602.10.7 Service Evaluation (Intermediate Care Facility for Individuals with an Intellectual Disability)

The provider shall comply with the conditions set forth in Chapter 42 of the Code of Federal Regulations (www.gpo.gov). In addition to certification reviews by

Department of Health Services, the Division's Quality Assurance Unit will do "Continued Stay Reviews" and "Active Treatment Reviews".

602.10.8 Service Closure (Intermediate Care Facility for Individuals with an Intellectual Disability)

The member shall be discharged from an ICF/IID as appropriate, in accordance with the following:

- A. A new Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document) and Cost Effectiveness Study shall be completed prior to the anticipated discharge, at least 10 days in advance, except in those cases where the discharge is of short duration, i.e., 5 days or less.
- B. A discharge plan shall be developed including the participation of the member and all Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) members and the discharge plan shall take precedence. The member/responsible person, the Primary Care Provider (PCP), the attending Physician and the Division's Medical Director shall resolve disagreements when there are differences between the Planning Documents and the discharge plan. The Division's Medical Director shall have the final authority as delegated by the Assistant Director.
- C. The member's PCP shall be given the opportunity to participate in the Individual Support Plan/Individualized Family Services Plan/ Person Centered Plan meeting (Planning Meeting) and to review the respective documents.
- D. The District Utilization Review Nurse shall participate in the Planning Meetings. The nurse shall ensure the discharge planning process has been completed and shall certify concurrence with the plan by signing these documents.
- E. The District Program Manager/District Program Administrator (DPM/DPA) shall certify concurrence by signing the discharge plan.
- F. The discharge plan, with the required signatures, shall be forwarded to the Division's Health Care Services (HCS) and Medical Director for final review and certification.
- G. The completed discharge package shall be returned to the DPM/DPA for implementation of the plan.

The entire process above shall be completed before the discharge is made.

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.11 Nursing Facility

602.11.1 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 under the daily direction of a physician.

The goal of this service is to provide an environment that meets and enhances the medical, physical and emotional needs of members residing in nursing facilities.

602.11.2 Service Settings (Nursing Facility)

Nursing facilities must be Medicare and Medicaid certified unless not available in the community. For the purposes of reimbursement by Arizona Long Term Care System (ALTCS) funding, the facility must be Medicaid certified.

602.11.3 Service/Provider Requirements (Nursing Facility)

Designated District staff must ensure the following are met before service is initiated:

- A. The NF must be licensed and certified by the appropriate Arizona state agencies and comply with all applicable federal and state laws relating to professional conditions, standards and requirements for NF(s).
- B. The NF must also comply with all health, safety and physical plant requirements established by federal and state laws.
- C. The Contractor must be registered with Arizona Health Care Cost Containment System (AHCCCS) to provide this service for that portion of the facility subject to Medicaid reimbursement.

602.11.4 Target Population (Nursing Facility)

Members in need of skilled nursing care on a 24-hour basis may be considered appropriate for this service. Prior to admission, the member must be screened in accordance with federal law (see Pre-Admission Screening/Annual Resident Review (PASRR) section of this policy manual) and reviewed for appropriateness of placement whenever a significant change in the physical or mental status of the member occurs.

602.11.5 Exclusions (Nursing Facility)

Long Term Care Services may be provided only in Medicare and Medicaid certified NF(s). State funded services do not need to be provided in Medicare or Medicaid certified facilities. No payments may be made for inappropriate placements pursuant to Chapter 42 Code of Federal Regulations 456.1 (www.gpo.gov, see also Section PASRR section of this policy manual).

The AHCCCS will advise the Division when a NF is placed on termination status due to noncompliance with Medicaid/Medicare participation requirements. No new admissions can be made to a NF on termination status.

Members currently residing in or on leave from a NF placed on termination status may remain in or return to the facility, if each member's Primary Care Provider (PCP) agrees with the District Utilization Review Nurse's assessment that the NF can continue to meet the needs of the member.

If the PCP or District Utilization Review Nurse does not feel the NF can meet the member's needs, the member must be offered a choice of available alternatives to include home and community based services.

Therapeutic leave shall not exceed 9 days and bed hold days shall not exceed 12 days per calendar year.

602.11.6 Service Provision Guidelines (Nursing Facility)

In addition to requiring a physician's order, a nursing assessment must be completed prior to NF Services being provided. This assessment will be done through the PASRR process.

602.11.7 Service Evaluation (Nursing Facility)

Members residing in NF(s) must be reviewed when there is a significant change in the physical or mental condition of the member (PASRR section of this policy manual) in addition to the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process (Planning Process). Physicians shall certify the need for nursing facility placement in accordance with Chapter 42 Code of Federal Regulations. www.gpo.gov

602.11.8 Service Closure (Nursing Facility)

Nursing Facility services will be terminated when there is no longer a need for 24-hour skilled nursing care, as determined by the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Document/Meeting) and the physician following the PASRR recommendations. The discharge shall occur as follows:

- A. A new Planning Document shall be completed prior to the anticipated discharge at least 10 days in advance except in those cases where discharge is of short duration, i.e., 5 days or less.

- B. The discharge plan shall be the document through which the discharge of the member is managed. All members of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall be involved in the discharge planning process and the discharge plan shall take precedence. The member or responsible person, the Primary Care Provider (PCP), attending Physician and the Division's Medical Director shall resolve disagreements regarding discharge planning.
- C. The member's PCP shall be given the opportunity to participate in the Planning Meetings and to review the respective Planning Documents.
- D. The District Utilization Review Nurse shall participate in the Planning Meetings. The District Utilization Review Nurse must also ensure discharge planning has been completed by signing these respective documents.
- E. The Division's District Program Manager/District Program Administrator (DPM/DPA) signature is also required on the discharge plan.
- F. The discharge plan with the required signatures shall be forwarded to the Division's Medical Services Manager.
- G. Health Care Services (HCS) and the Division's Medical Director shall conduct the final review.
- H. The complete discharge package shall be returned to the DPM/DPA for implementation of the plan

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.12 Respite

602.12.1 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.

602.12.2 Service Settings (Respite)

Respite may be provided in 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.

602.12.3 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.
 - 8. Ensure appropriate consideration of member needs, compatibility and safety when caring for unrelated members.

602.12.4 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). <https://www.azdes.gov/azeip/>

602.12.5 Exclusions (Respite)

Exclusions to the provision of Respite services may include 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. Foster care (child developmental homes) and adult developmental home providers shall not give services to more members than would exceed their Division license.
- E. Foster care (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.
- 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.

602.12.6 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 Long Term Care. 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 Long Term Care Service 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://www.azdes.gov/uploadedFiles/Developmental_Disabilities/ddd_ratebook.pdf.
- 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.

602.12.7 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 Long Term Care Services must be certified by the Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.12.8 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.
- 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).

602.12.9 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 Arizona Long Term Care System (ALTCS) shall terminate when the maximum amount allowed has been used and there are no State funds available.

A Notice of Intended Action must be sent in accordance with the processes defined in of this policy manual.

602.13 Room and Board

602.13.1 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.

602.13.2 Service Settings (Room and Board)

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

602.13.3 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
- B. Nutritional maintenance for members served must be ensured and provided.

602.13.4 Target Population (Room and Board)

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

602.13.5 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.

602.13.6 Service Provision Guidelines (Room and Board)

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602.13.7 Provider Types and Requirements (Room and Board)

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

602.13.8 Service Evaluation (Room and Board)

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

602.13.9 Service Closure (Room and Board)

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

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.14 Therapies – Occupational, Physical and Speech

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.
- 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.
- 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.
- 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.
- 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. DD/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.

602.15 Respiratory Therapy

602.15.1 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.
- B. Improve the functional capabilities and physical well-being of the member.

602.15.2 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).

602.15.3 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 Long Term Care services and registered with the Arizona Health Care Cost Containment System (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.
 9. Giving instruction on the use and care of special equipment to the member and care providers.

602.15.4 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).

602.15.5 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).

602.15.6 Service Provision Guidelines (Respiratory Therapy)

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

602.15.7 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 Long Term Care Services must be registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.15.8 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.

602.15.9 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.
- E. The member/responsible person 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 this policy manual.

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.

602.15.10 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 the 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.

602.16 Transportation (Non-Emergency)

602.16.1 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 prior 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.

602.16.2 Service Requirements (Transportation)

Transportation can be provided for members who are eligible for Long Term Care to and from other covered services.

602.16.3 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.

602.16.4 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 for Long Term Care Services to medical appointments should be coordinated through the health plan.

- C. Members residing in Vendor Supported Child Developmental Homes and Vendor Supported Adult Developmental Foster Homes, Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Group Homes shall not receive additional transportation.

602.16.5 Service Provision Guidelines (Transportation)

- A. Members who are eligible for Long Term Care services may use forty-six (46) trips per month to covered day programs.
- B. Members who are eligible for Long Term Care services may use eight (8) trips per month to other covered services.

602.16.6 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 Long Term Care services must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.16.7 Service Evaluation (Transportation)

This service shall be reviewed at all Planning Team meetings.

602.16.8 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.

603 Acute Care Service Delivery

The Division, as a program contractor for Arizona Long Term Care System (ALTCS), is responsible to provide acute care services to members who are eligible for Long Term Care services.

603.1 Contracted Health Plans

Members who are eligible for Long Term Care services are required to join one of the Division's contracted health plans, where available. The exception is Native Americans who may choose to enroll in American Indian Health Plan.

The contracted health plan subcontracts with physicians, hospitals, therapists, dentists, laboratories, pharmacies, medical equipment suppliers and other providers to deliver acute care services to enrolled members.

All services must be delivered or ordered by the Primary Care Provider (PCP), determined to be medically necessary by the health plan and delivered by a contracted provider. The PCP is the member's designated physician who coordinates all aspects of the member's medical care. Members who are eligible for Long Term Care services that fail to follow these procedures and receive services that are not approved/provided by a health plan provider are responsible to pay for these services.

The members who are eligible for Long Term Care services may choose to use their own doctor if the physician is an Arizona Health Care Cost Containment System (AHCCCS) registered provider and is contracted with the health plan. In these instances, the health plan's or the Division's approval is still needed for services covered by Arizona Long Term Care System.

If the member who is long term care eligible is enrolled in a health plan and has a Primary Care Provider (PCP), but also chooses to use another physician who may not be registered with AHCCCS, services provided or ordered by this physician are not covered by the AHCCCS. Services by a physician who is not registered with the AHCCCS can be covered by the health plan if approved by the PCP and the health plan. If approval is not received from the PCP and the health plan, the member will be required to pay for the services personally or through private insurance.

Children's Rehabilitative Services (CRS)

Members eligible for ALTCS may also be eligible for Children's Rehabilitative Services (CRS). Members eligible for the Division and CRS will receive CRS specialty services and behavioral health services through United Healthcare Community Plan or its successor. These members will continue to receive acute care services through their Division acute health plan.

Comprehensive Medical and Dental Program

The Comprehensive Medical and Dental Program (CMDP) is a health care program for Arizona's children who are wards of the court and placed out of home. Eligibility is based on State law. Child Protective Service (CPS) coordinates services related to CMDP.

Member Acute Care Card

Members who are determined eligible for Long Term Care services will receive a membership card from the Division or the Division's contracted acute health plan, and will be enrolled in a contracted acute health plan by the Division or receive services on a fee-for-service basis through the Division.

Health Plan Responsibilities

Each contracted acute health plan is required to send members a health plan member handbook. The handbook explains the services that are covered, how to access these services, and what to do when emergency services are needed. It outlines the member's responsibility to follow procedures. All services must be provided or approved by the primary care provider

An ALTCS member who fails to follow procedures outlined in the member handbook and receives services that are not approved or provided by a health plan contracted physician may be responsible to pay for those services.

The Division may delegate some or all of its responsibility to a health plan for the following non-inclusive health care responsibilities. These services are rendered on behalf of members who are ALTCS members and enrolled with the health plan:

- A. Prior authorization of services and procedures as specified by the health plan.
- B. Claims processing according to policies and procedures defined by the health plan.
- C. Concurrent review, including certification and denial of inpatient hospital stay days, according to health plan procedures.
- D. Investigation and resolution of complaints and grievances according to policy and procedure specified by both AHCCCS and the health plan.
- E. Provider relations and member services activities.
- F. Financial monitoring and reporting as mandated under AHCCCS rules.
- G. All other quality assurance and utilization management activities as defined in the Title 42 of the Code of Federal Regulations (<http://www.gpoaccess.gov/cfr/>), AHCCCS Rules (azahcccs.gov/Regulations/), and the health plan's quality assurance/utilization review procedures.

All such services/responsibilities must be in compliance with AHCCCS/ALTCS Rules and Regulations (azahcccs.gov/Regulations/).

604 Acute Care Services

604.1 Inpatient Hospital (Acute Care Services)

Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These

services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

The following is a list of the minimum inpatient hospital services that are available to members who are eligible for Long Term Care services.

Routine services including:

- A. Hospital room and board.
- B. Medical supplies, appliances and equipment ordinarily furnished to hospital inpatients that are billed as part of routine services and are included in the daily room and board charge.
- C. Intensive care and coronary care.
- D. Nursing care.
- E. Dietary management.
- F. Up to seventy-two (72) hours of acute behavioral health services. The health plans will provide acute behavioral health services in accordance with AHCCCS Rules for members not enrolled with a Regional Behavioral Health Authority (RBHA). The RBHA provides acute behavioral health services for their enrollees.

Supplementary services including:

- A. Maternity services including labor, delivery, recovery rooms, and birthing centers.
- B. Surgery, including operating and recovery rooms.
- C. Clinical laboratory.
- D. Radiological and medical imaging.
- E. Anesthesiology.
- F. Rehabilitation including speech, occupational and physical therapies.
- G. Pharmaceutical services.
- H. Respiratory therapy.
- I. Receiving blood and blood products.

- J. Receiving central supply items including appliances and equipment that are not ordinarily furnished to all patients and that are customarily reimbursed as additional services.
- K. Nursery and related services.
- L. Chemotherapy services.
- M. Dialysis in accordance with AHCCCS http://www.azsos.gov/PUBLIC_SERVICES/Table_of_Contents.htm
- N. Total parenteral nutrition services.
- O. Podiatry services, as covered in the AHCCCS policy 2.14.0, ([azahcccs.gov/Regulations](http://www.azahcccs.gov/Regulations)) performed by a podiatrist, licensed pursuant to A.R.S. Title 32, Chapter 7 (<http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp>), and ordered by a Primary Care Provider (PCP).

604.2 Outpatient Services (Acute Care Services)

Outpatient health care services are those services provided outside of the acute care inpatient hospital setting. These include both palliative (designed to alleviate pain and discomfort) and therapeutic (designed to improve the condition) services directed or administered by a PCP. The services may be preventive, diagnostic or rehabilitative in nature. The following minimum outpatient health care services may be provided to members who are eligible for services through the Arizona Long Term Care System (ALTCS):

- A. Ambulatory surgery and anesthesiology not specifically excluded by the AHCCCS Rules. [azahcccs.gov/Regulations](http://www.azahcccs.gov/Regulations)
- B. Physician services including patient education and routine physical examinations as designated by the AHCCCS policy and procedures. [azahcccs.gov/Regulations](http://www.azahcccs.gov/Regulations)
- C. Pharmaceutical services and prescribed drugs included in the Division's Formulary. Also including vaccines to prevent Hepatitis B, medically necessary psychotropic for the control of seizures and spasticity and non-prescription medication when cost-effective and prescribed by a physician.
- D. Clinical laboratory services, including routine screening for Hepatitis B.
- E. Radiological and medical imaging.

- F. Services of nurse practitioners and physician assistants when referred by or under the supervision of a PCP.
- G. Nursing services provided in an outpatient health care facility.
- H. Covered medical supplies and equipment authorized by the member's PCP.
- I. The use of twenty-four (24) hour emergency, examination or treatment rooms when required for the administration of physician services. Emergency room and medical emergency service will be provided 24 hours a day, 7 days a week.
- J. Podiatry services, as covered in the AHCCCS Policy and Procedure Manual 2.14.0 (azahcccs.gov/Regulations), performed by a podiatrist, licensed pursuant to A.R.S. Title 32, Chapter 7, (azleg.gov/ArizonaRevisedStatutes.gov) and ordered by a Primary Care Provider (PCP).
- K. Home physician visits as medically necessary.
- L. Dialysis in accordance with the AHCCCS Rules. azahcccs.gov/Regulations
- M. Specialty care physician services shall be considered covered services only when requested by a PCP.
- N. Rehabilitation services including occupational, physical and speech therapies prescribed by a PCP and in accordance with the AHCCCS Rules. azahcccs.gov/Regulations
- O. Respiratory therapy.
- P. Total parenteral nutrition services.
- Q. Enteral nutritional supplements when prescribed as medically necessary by a PCP.
- R. Annual physical examinations for adults and children, periodic health examinations, health assessments, physical evaluations, diagnostic procedures or health protection packages, that include groups of tasks or procedures designed to:
 - 1. Determine risk of disease.
 - 2. Provide early detection of disease.
 - 3. Detect the presence of injury or disease at any stage.

4. Establish a treatment plan for injury or disease.
 5. Evaluate the results or progress of a treatment plan for the disease.
 6. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.
- S. Outpatient behavioral health services, including psychotropic medications, in accordance with the AHCCCS Rules.
- T. Medically necessary home nursing in lieu of hospitalization when ordered by the Primary Care Provider (PCP).
- U. Hospice services.

604.3 Clinical Laboratory, Radiological and Medical Imaging Services (Acute Care Services)

Clinical laboratory procedures (including routine screening for Hepatitis B), radiological and medical imaging services prescribed by a Primary Care Provider (PCP) or by another physician, practitioner or dentist upon referral by a PCP and which are ordinarily administered in hospitals, clinics, physicians' offices or other health care facilities by licensed health care providers shall qualify as covered services if medically necessary.

Clinical laboratory, radiological and medical imaging service providers shall satisfy all applicable State license and certification requirements, be registered with the Arizona Health Care Cost Containment System (AHCCCS), and shall perform only those services specific to their license and certification.

604.4 Pharmacy (Acute Care Services)

Pharmaceutical services include medically necessary drugs prescribed by Primary Care Provider (PCP), other physicians, practitioners or dentists upon referral by a PCP. Psychotropic drugs for the control of seizures and spasticity shall be covered, as well as vaccines used to prevent Hepatitis B. At a minimum, items listed in the Division's Formulary shall be included as covered benefits for members who are eligible for Long Term Care services.

Psychotropic drugs for behavioral health symptoms shall be covered according to the AHCCCS Rules.

Prescriptions shall be dispensed with a 30-day supply of medication, if authorized by the prescriber.

Pharmaceutical services shall be available to members during customary business hours and shall be located within reasonable travel distance.

604.5 Medical Supplies, Durable Medical Equipment, and Prosthetic Devices
(Acute Care Services)

Medical supplies, durable medical equipment orthotic and prosthetic devices provided to members who are eligible for Long Term Care services qualify as covered services if prescribed by a, specialist physician, practitioner or dentist upon referral by a 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.

Experience has demonstrated that the cost-effective provision of Durable Medical Equipment includes the involvement of a physical therapist in ordering and fitting customized equipment.

Medical supplies and Durable Medical Equipment include:

- A. Surgical dressings, splints, casts and other disposable items covered by Medicare (Title XVIII).
- B. Rental or purchase of Durable Medical Equipment, including, customized equipment.
- C. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

604.6 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. Stenders, prone and upright.

- E. Toileting aids.
- F. Wedges (positioning).
- G. Transfer aids.
- H. Augmentative communication devices.
- I. Medically necessary car seats.
- J. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

604.7 Dental Services

Dental services for members who are Long Term Care eligible aged 0 to 21 years are covered when provided by a licensed dentist per A.R.S. §32-1207 and A.R.S. §32-1231 for maintenance of dental health, prevention and treatment of disease and injury, in an appropriate dental facility.

Informed consent must be obtained from the member or responsible person(s) prior to any treatment including those noted in #1 below. Written consent must be obtained prior to major outpatient treatments. The dentist must obtain the consent.

The following services are covered:

- A. Preventive dental services - performed annually unless otherwise requested by Primary Care Provider (PCP) include:
 - 1. Oral examinations.
 - 2. Radiological and medical imaging services.
 - 3. Oral prophylaxis - includes scaling and polishing and application of topical fluoride and sealants, if appropriate.
 - 4. Dental treatment plan.
 - 5. Dental education.
- B. Restorative treatment, including:
 - 1. Restorative and primary amalgams.
 - 2. Composite restoration (anterior teeth).
 - 3. Sedative base.

- 4. Permanent teeth.
 - C. Orthodontia when medically necessary and prior authorized by the health plan or the Division's Medical Director.
 - D. Endodontic services (pulp capping, pulpotomy and recalcification).
 - E. Crown and bridge services.
 - F. Prosthetics.
 - G. Oral surgery includes extraction of symptomatic teeth and post-operative visits.
 - H. Orthognathic surgery.
 - I. Medically necessary dentures.

604.8 Rehabilitative Therapy

Rehabilitation is the process of re-establishing former functions or skills. This includes physical, occupational and speech therapies. This service may occur after a trauma has decreased the functioning of a member. Rehabilitative therapies are not designed to build a skill or functioning level that had not been previously present in the member.

604.9 Maternal and Child Health

There are several programs that support maternal and child health. These include Early and Periodic Screening, Diagnosis and Treatment (EPSDT), family planning, pregnant women's program and mental health. These programs are described below:

- A. EPSDT is the component of the Medicaid Program established in 1969 as the federally mandated screening and treatment program for children birth to age 21.

The goal of EPSDT is to provide health care through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems identified by well child checks and screens.

An EPSDT must include:

- 1. A comprehensive health and developmental history (including both physical and behavioral health assessment).

2. As of January 1, 2006, the Prenatal Evaluation of Development Status (PEDS) developmental screening tool should be utilized for developmental screening by the primary care provider for EPSDT-age members who were admitted to the neonatal intensive care unit. The PEDS screening should also be conducted at each EPSDT well child visit.
3. A comprehensive unclothed physical examination.
4. Appropriate immunizations according to age and health history.
5. Laboratory tests (including blood lead levels).
6. Health education.
7. Appropriate dental screening.
8. Appropriate vision screening and hearing testing.
9. Diagnostic services whenever a screening examination indicates the need to conduct a more in depth evaluation of the child's health status and to provide diagnostic studies.

As the Medicaid authority in Arizona, AHCCCS administers the Early and Periodic Screening Diagnosis and Treatment program. Children who are eligible for Medicaid are eligible for EPSDT services. Children who are eligible for Long Term Care services are also Medicaid eligible. Additionally, these children are eligible for EPSDT services.

Arizona Health Care Cost Containment System (AHCCCS), contracts with health plans to provide all EPSDT services to all AHCCCS eligible children in Arizona.

The Division also contracts with the health plans to provide EPSDT services to children who are Long Term Care eligible. The Division provides those services identified as habilitative to children who are Long Term Care eligible. The health plans are under contract to provide rehabilitative services to children who are Long Term Care eligible.

Medicaid funds are available to pay for medically necessary services identified for a child with a disability in his/her Individualized Educational Plan, Individual Family Service Plan, Individual Support Plan or Person Centered Plan.

All services authorized in the federal Medicaid law must be provided to children who are eligible for EPSDT. These services include:

1. Screening.
2. Evaluation.
3. Clinic services.
4. Rehabilitative services.
5. Physical therapist services.
6. Occupational therapist services.
7. Speech pathology and audiology services.
8. Psychological treatment.
9. Social services.
10. Inpatient psychiatric facility services.
11. Outpatient behavioral health services.

An authorization for services can only be denied for lack of a finding of medical necessity. It cannot be denied for any other reason for children who are eligible for the AHCCCS program and Division services.

EPSDT means those procedures or professional services which are required to maintain, correct or ameliorate a physical, emotional or developmental problem which is discovered through screening, examination or evaluation or which is found to have worsened since a previous screening.

For more detailed information on EPSDT, refer to the AHCCCS Medical Policy Manual at Section 430. www.azhcccs.gov/Regulations

- B. Family Planning - Medicaid allows for the provision of Family Planning Services. The goal of Family Planning Services is to enable a member to make choices in both the timing and occurrence of pregnancies. This service is available through the member's Primary Care Provider (PCP) and is part of the services offered by the health plans. Division health plans are required to educate their Providers on the full scope of available family planning services and how members may obtain them.
- C. Pregnant Women's Program - One step toward accomplishing this goal is to ensure that pregnant women receive early and continuous prenatal care from a qualified obstetrical provider. Prenatal care is arranged through the member's PCP.

- D. Behavioral Health Programs – members who are eligible for Long Term Care services needing behavioral health services may be referred by their Division Support Coordinator, the Division Behavioral Health Coordinator, and the physician or by themselves to a Regional Behavioral Health Authority (RBHA) for evaluation and service planning. Covered services must comply with the AHCCCS behavioral health policies and procedures. Inpatient and outpatient services are covered as well as appropriate prescription drugs.

604.10 Podiatry

Routine foot care can be covered when the performance of such services by other than professional members would be hazardous to members who have concurrent diseases such as diabetes mellitus or thrombophlebitis.

604.11 Organ Transplant

Organ transplant services and procurement shall be in accordance with AHCCCS Rules (www.azhcccs.gov/Regulations). Organ transplant services also require written prior authorization from the Division and AHCCCS.

604.12 Extended Care Coverage

Health plans for members who are eligible for Long Term Care are financially responsible for a maximum of 90 days. This financial responsibility includes nursing facility care, and room and board, after -hospital discharge. Nursing Facility (NF) care must be in lieu of hospitalization. If the member's place of residence prior to hospitalization was a NF the health plan is not financially responsible for placement. Members requiring nursing facility placement beyond 90 days are the financial responsibility of the Division. Preadmission Screening/Annual Resident Review (PASRR) Level II reviews must occur for each member whose expected stay in the NF will exceed 90 days

Division staff will work expeditiously with the health plan's discharge planners to place the member in the least restrictive environment as required by state law.

604.13 Home Health Services

Home health services through the health plan are those services provided by a Home Health Agency that coordinate in-home intermittent services. These services include, home health aide services, medical supplies, equipment and appliances. The service must be ordered by the Primary Care Provider (PCP) in lieu of hospitalization and referred by the health plan to a Medicare Certified Home Health Agency.

604.14 Emergency Ambulance and Medically Necessary Transportation

Emergency transportation via ground or air ambulance and transportation to access acute care services is a covered benefit. Transportation services are limited to occasions when no other means of travel is appropriate or available or in emergency situations. The nearest provider or medical facility capable of meeting the member's medical needs shall be utilized.

604.15 Travel Expenses (Meals, Lodging, Transportation and Attendant Services)

Expenses incurred for meals, lodging and transportation for a member while en route to or from a health care service site out of the member's service area or county of residence are covered services.

The PCP must write an order for attendant care services. The Attendant Care Provider's meals, lodging and transportation expenses are covered. On occasion the Attendant Care Provider may accompany a member out of the service area or county of residence. These attendant care providers may also be a family member who lives in the same household as the member. Under these circumstances services are covered if a written order from the PCP is issued. The Attendant Care Provider's salary is covered only if the attendant does not live in the same household as the member. Expense receipts must be sent to the health plan or Health Care Services for fee-for-service counties. Receipts for meals and lodging must not exceed the State per diem. Transportation will be reimbursed at 9 cents per mile.

The following exclusions and limitations apply:

- A. Family household members, friends and neighbors may be reimbursed for providing transportation services only if the services are ordered in writing by the PCP and free transportation or public transportation is not available.
- B. A charitable organization providing transportation services at no cost. A charitable organization may not charge or seek reimbursement for the provision of such services to Long Term Care.
- C. Payment for meals, lodging and transportation of a member and an Attendant Care Provider are funded when a member requires covered service that are not available in the health plan's service area. This criterion also applies to the salary for an attendant.

604.16 Out-Of-Area Coverage

Out of Area Service

Arizona Long Term Care System (ALTCS) eligible members who need emergency medical services when out of the service area may go to an emergency room.

Emergency medical services are those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate attention could be expected to result in:

- A. Placing the patient's health in serious jeopardy
- B. Serious impairment of bodily functions
- C. Serious dysfunction of any bodily organ or part

Providers must notify the health plan within 12 hours of emergency service provision. Non-emergency services out of the member's service area will not be covered.

Services cannot be provided to a member outside the United States.

Covered services are required to be provided within the service area of the health plan except as follows:

- A. Referral of a member by a PCP, out of the health plan's service area for medical specialty-care (including Children's Rehabilitative Services).
- B. Services for members traveling or temporarily residing out of their health plan's service area are restricted to emergency care services, unless otherwise authorized by the health plan.
- C. A covered service is not available within the health plan's service area.
- D. A net savings results from transportation to another area for services.
- E. The health plan provides written authorization for services based on cost or scope of service considerations.

604.17 Incontinence Briefs

- A. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups and incontinence pads, for members who are between 3 and 21 years of age and who are eligible for the ALTCS program. Briefs may be provided in order to prevent skin breakdown and to enable participation in social, community, therapeutic and education activities. These supplies will be provided under the following circumstances:
 - 1. The member is incontinent due to a documented disability that caused incontinence of bowel and/or bladder.

2. The PCP or attending physician has issued a prescription ordering the incontinence briefs.
3. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder.
4. The member obtains incontinence briefs from providers in the Contractor's network.
5. Apply appropriate prior authorization requirements. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit.

Prior authorization is permitted to ascertain that:

- i. The member is over age 3 and under age 21;
 - ii. The member has a disability that causes incontinence of bladder and/or bowel;
 - iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard brief supplied by the contractor; and,
 - iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
- B. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups, for members 21 years of age and older to treat a medical condition or to prevent skin breakdown when all the following are met:
1. The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder.
 2. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
 3. Incontinence briefs do not exceed 180 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 180 briefs per month;

4. The member obtains incontinence briefs from vendors within the Contractor's network; and,
 5. Prior authorization has been obtained if required by the Administration, Contractor, or Contractor's designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every 12 months.
- C. The Division shall provide incontinence briefs for members who are between 3 and 21 years of age who are:
1. Group home residents that do not qualify for Medicaid (ALTCS or targeted).
 2. Group home residents that qualify for Medicaid (ALTCS) and have been denied incontinence briefs by the assigned health plan and other medical insurance coverage (e.g., Medicare), if applicable.
- D. Authorized services must be for at least a 12 month period of time.
- E. Contractors may require a new prior authorization to be issued no more frequently than every 12 months.
- F. Incontinence briefs will not be covered by Children's Rehabilitative Services (CRS).
- G. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.
- H. If a member is eligible for Fee For Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.
- I. Any exceptions to this policy section must have the approval of the Assistant Director.

604.18 Supplemental Nutritional Feeding

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

604.18.1 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, etc.
 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.
 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:
 - i. Members on oral-enteral formulas less than five (5) years shall receive an assessment every three (3) months.

- ii. Members on oral-enteral formulas five (5) to fourteen (14) years shall receive an assessment every six (6) months.
 - iii. Members on oral-enteral formulas over fourteen (14) years shall receive an assessment annually.
 - 2. Alternatives to commercially prepared formulas should 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 Women, Infant and 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.

604.18.2 Member Management (Supplemental Nutritional Feeding)

Members should be followed by:

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

604.18.3 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:

- i. 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.
 - ii. The member has reached a plateau in growth and/or nutritional status for greater than six months (pre-pubescent).
 - iii. The member has demonstrated a decline in growth status within the last three months.
 - iv. The member is able to obtain/eat no more than 50% of his/her nutritional requirement from normal food sources.
 - v. Absorption problems as evidenced by emesis, diarrhea, dehydration, weight loss and intolerance to milk or formula products have been ruled out.
 - vi. 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 Section 604.19.1.b).

604.19 Service Provision Guidelines (Supplemental Nutritional Feeding)

Covered services may be limited in amount, duration and scope. Certain services are specifically excluded from coverage. These limitations and exclusions are documented in AHCCCS Rules and apply to all covered acute care services.

Exclusions include:

- A. Services rendered by non-registered providers.
- B. Services or items furnished solely for cosmetic purposes.
- C. Services for which required prior authorization was not obtained from the health plan.
- D. Services or items furnished gratuitously or for which charges are usually not made.

- E. Services rendered in a public institution for treatment of tuberculosis or for the treatment of mental disorders for members between ages 21 and 65.
- F. Hearing aids for members age 21 and older.
- G. Treatment and services determined to be experimental or provided primarily for the purpose of research.
- H. Services of a private or special duty nurse except when medically necessary and with prior authorization by the health plan.
- I. Sex change operations.
- J. Reversal of voluntarily induced infertility;
- K. Care not deemed medically necessary by Health Care Services, the PCP or not included in the AHCCCS Rules.
www.azahcccs.gov/Regulations
- L. Medical services provided to a member who is an inmate of a public institution as defined in Chapter 42 Code of Federal Regulations 435.1009 (www.gpoaccess.gov/cfr/) or who is in the custody of a State mental health facility.
- M. Artificial, mechanical, or xenograft heart transplant.
- N. Organ transplants except those specifically covered by A.R.S. §36-2907(A) (E) (F) azleg.gov/ArizonaRevisedStatutes.asp as authorized by the health plan.
- O. Abortions not medically necessary.
- P. Hysterectomies which are not medically necessary.
- Q. Abortion counseling.
- R. Optional family planning clinic services as defined by federal law.

Services cannot be denied based on moral or religious grounds.

605 Medical Marijuana

Medical marijuana is not a covered medical or pharmacy benefit. Office visits or any other services that are for the purpose of determining if a member would benefit from medical marijuana are also not covered. Under no circumstance shall any employee of the Department and any owner, director, principal, agent, employee,

subcontractor, volunteer, and staff of the Division's service providers administer or store medical marijuana for Division members.