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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

INTRODUCTION

The Commonwealth of Virginia offers several home and community-based waivers under the Medical Assistance Program.

The waivers differ according to the populations they serve, the medical and functional criteria for eligibility, the pre-admission screening (PAS) process, and the services offered under each waiver. Under no circumstances can an individual be enrolled in and receive services under more than one waiver during the same time period.

ALZHEIMER'S ASSISTED LIVING (AAL) WAIVER

The Department of Medical Assistance Services (DMAS) provides payment for the services provided in the Alzheimer's Assisted Living (AAL) Waiver, which offers individuals an alternative to nursing facility (NF) placement and allows them to remain in a home-like setting for as long as possible. The AAL Waiver was designed to be available to older adults and individuals with disabilities with diagnosis of either Alzheimer's or Alzheimer's related dementia who receive an Auxiliary Grant (AG) and reside in a licensed assisted living facilities (ALFs) with a specialty care unit designation.

The community PAS Team or hospital discharge planner must determine the individual eligible for AAL Waiver services. DMAS or its service authorization contractor must authorize all waiver services in order for any provider to be reimbursed. Individuals may be authorized to receive services based on the documented need for the service(s) and the individual's choice of services and providers. All service authorizations must be renewed every 12 months.

This chapter of the manual will describe the covered services and limitations of this waiver including, and not limited to, the individual eligibility requirements, the standards for provision of services, ALF administrators and licensed health care professional (LHCP) requirements, record documentation requirements, and required individual activities.

WAIVER DESCRIPTION AND LEGAL AUTHORITY

The AAL waiver operates under the authority of § 1915 (c) of the Social Security Act and 42 CFR 430.25(c)(2), which permit the waiver of certain State Plan requirements. These federal statutory and regulatory provisions permit the establishment of Medicaid waivers to afford the states with greater flexibility to devise different approaches to the provision of long-term care services. This particular waiver provides eligible individuals who have a

diagnoses of Alzheimer's or related dementias with supportive services to enable such individuals to remain in their communities as defined in 12VAC 30-120-1605.

SCREENING PROCEDURES FOR AAL WAIVER SERVICES

Individuals seeking placement in the AAL waiver must meet the waiver's alternative institutional placement which is a nursing facility. For individual's in the community, the local PAS Team which is composed of a social worker with the local department of social services (LDSS), a nurse from the local department of health, and the local health department physician completes the screening. For individuals who are hospital inpatients, the hospital discharge planning staff completes the screening. The appropriate screeners must have explored the medical, social, and nursing needs of the individual, analyzed the specific service needs of the individual, and evaluated whether a service or combination of existing services is available to meet these needs. The screeners must have explored alternative settings and services to provide the required supports before making the referral for the AAL Waiver services. (See the *Pre-Admission Screening Provider Manual*.)

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under the waiver must only be provided to individuals who have a need for the level of care provided in the alternative institutional placement when there is a reasonable indication that an individual might need the services unless he or she receives home or community-based services. Under the AAL Waiver, services may be furnished only to individuals:

1. Who are financially eligible for Medicaid;
2. Who are financially eligible to receive Auxiliary Grant payments through the Department of Social Services;
3. Who meet the nursing facility criteria as outlined in the Pre-Admission Screening Manual;
4. For whom an appropriate, cost-effective Individual Services Plan can be established;
5. Who are not residents of NFs (licensed by the Virginia Department of Health);
6. When there are no other or sufficient community resources to meet the individuals' needs;
7. Whose health, safety, and welfare (HSW) in the home environment can be ensured;
8. Have a diagnosis of Alzheimer's or Alzheimer's related dementia but not intellectual disability or serious mental illness (42CFR483.102(b); and
9. Are age 55 years or older.

AAL Waiver services must be the critical services that enable the individual to remain in the community than being placed in a NF. For more information regarding the pre-

admission screening program, please refer to the DMAS *Pre-Admission Screening Manual*. This manual is available on the DMAS website: www.virginiamedicaid.dmas.virginia.gov.

AUTHORIZATION FOR MEDICAID PAYMENT OF AAL SERVICES

Screening by the community PAS Team or hospital discharge planner, as appropriate, and authorization of AAL Waiver services by the service authorization contractor is mandatory before Medicaid will reimburse for AAL Waiver services. Medicaid will not pay for any AAL Waiver services delivered prior to the authorization date of the physician's signature on the DMAS-96. The date of this authorization cannot be made prior to the date on which the assessment is completed and the PAS Team or hospital discharge planner makes a decision. Medicaid will not pay for any AAL Waiver services delivered prior to the individual's effective date of Medicaid eligibility and qualification for an Auxiliary Grant (AG).

Reimbursement for AAL Waiver services can only be made during AAL enrollment periods and when there is a valid, approved service authorization that states the individual's name, Medicaid ID number, specific service and units, dates of service, provider name, and provider ID number.

Screenings for the AAL Waiver and determinations of Medicaid and Auxiliary Grant eligibility are two separate and distinct processes. Once is not dependent upon the other. Screenings cannot be delayed while the eligibility determinations are being made.

FORMS REQUIRED FOR ADMISSION TO ALZHEIMER'S ASSISTED LIVING WAIVER SERVICES

The pre-admission screening team or hospital discharge planner which is initiating a referral must call the AAL waiver provider first to notify the provider that the individual has chosen the facility for services and to determine if the AAL waiver provider is able to initiate services promptly for the individual. If the provider can accept the referral, the screener will send the provider a complete admission packet required for the facility to admit the applicant for AAL Waiver services. The AAL waiver provider must be enrolled with DMAS to provide AAL waiver services and licensed in good standing by the Virginia Department of Social Services (VDSS) Division of Licensing Programs.

If the AAL waiver provider does not receive an entire, thoroughly completed packet of referral forms from the screener, as noted below, the provider must notify the responsible PAS team and request the complete packet. A provider will not be reimbursed for services without the copy of the Long Term Care Pre-Admission Screening Authorization (DMAS-96), completed by the screener.

The forms which must be thoroughly completed by the screener and forwarded to the AAL provider are:

- A full 12-page **Uniform Assessment Instrument** (UAI) completed by the PAS Team; and
- The **Long-Term Care Pre-Admission Screening Authorization** (DMAS-96) completed by the screener (which includes the physician signature and date).
- The service authorization must be completed for the appropriate level of care and must be signed and dated by the screener and the physician prior to the start of services.

Screeners will make AAL Waiver service referrals only to ALFs that have met DMAS requirements, are enrolled under contract as a DMAS AAL Waiver provider, and who are in good standing as licensed ALF with VDSS.

ALZHEIMER ASSISTED LIVING WAIVER PROVIDER RESPONSE TO REFERRAL

The AAL Waiver provider shall not begin services for which Medicaid reimbursement is expected until the completed admission packet is received from the screener and not before the date authorized by the PAS team on the DMAS-96.

It is the AAL Waiver provider's responsibility to determine whether the facility can adequately provide services to an individual prior to accepting a referral for services.

DETERMINATION OF MEDICAID ELIGIBILITY

Every individual who applies for Medicaid-funded long-term care must have his or her Medicaid eligibility evaluated, or re-evaluated, if already Medicaid eligible, by the local department of social services (LDSS) in the city or county in which he/she resides. Medicaid will pay for AAL Waiver services only after the LDSS has determined that the individual is eligible for medical assistance for the dates services are to be provided. For questions about eligibility criteria or an individual's eligibility status, contact the local DSS eligibility worker. Enrollment in this waiver requires that the individual be determined eligible to receive AG payments; this is also determined by the LDSS.

MEDICAID APPLICATION PENDING

DMAS cannot pay for AAL Waiver services unless:

1. The screening has been completed by the community PAS Team or hospital discharge planner, as appropriate, with a determination that the individual meets AAL criteria and waiver services are appropriate;
2. The authorization of AAL Waiver services by the service authorization contractor has been completed;
3. The individual is Medicaid-eligible on the dates that services are to be rendered; and

4. The individual receives services that are covered under the AAL Waiver as defined by DMAS.

There may be cases in which the individual has been assessed through the PAS process and determined eligible for the AAL Waiver, but Medicaid financial eligibility has not been determined/re-determined.

In these cases, the provider may choose to provide services, while awaiting the financial eligibility decision by the LDSS regarding Medicaid financial eligibility, but does so without a guarantee of payment from DMAS. The provider cannot bill for services provided until the provider verifies that Medicaid has been approved for waiver services via a DMAS-225 from the LDSS and service authorization has been obtained for the service, units, and dates of service.

In some instances, the provider may accept a referral and start care when the individual's Medicaid financial eligibility is in a pended status. In these instances, the provider must continue to hold the enrollment package until obtaining a valid Medicaid number. If there is difficulty confirming the individual's financial eligibility status, contact the eligibility worker's supervisor in the LDSS and, if the supervisor is unable to resolve the questions, contact the regional eligibility specialist. Information on regional offices can be found at the following site: http://www.dss.virginia.gov/division/regional_offices/index.cgi

The service authorization request must be submitted to the service authorization contractor within 10 business days of the receipt of verification of Medicaid eligibility (DMAS-225) in order for services to be authorized retroactively to the start of services date. No payment will be made for services until Medicaid eligibility is established and authorization has been obtained from the service authorization contractor. No correspondence or invoices should be included with the enrollment or services requests other than the required forms and documentation as specified in Appendix D or on the Service Authorization's website. The service authorization contractor will ensure that level of care criteria and the appropriateness of AAL Waiver services have been met. Any enrollment or service authorization request that is incomplete or submitted incorrectly will be pended by the service authorization contractor, and the provider will be notified. The information must be submitted within the timeframe given on the request for information notice or the request may be rejected, denied, or partially approved. A computer-generated letter from the Medicaid Management Information System (MMIS) will be sent to the provider and individual receiving waiver services confirming the authorized service, dates and units.

LONG-TERM CARE (LTC) COMMUNICATION FORM (DMAS-225)

The LTC Communication Form (DMAS-225) is used by the LDSS to inform providers of Medicaid eligibility and to exchange information. Immediately upon initiation of services, the provider must send a DMAS-225 to the eligibility unit of the appropriate local LDSS indicating the provider's first date of service delivery. The LDSS eligibility worker will complete an eligibility determination and notify the individual confirming the date the individual's Medicaid eligibility is effective, and the Medicaid identification number and will notify the provider via the DMAS-225 of the outcome of the eligibility determination. The provider will be given the begin date of eligibility and the Medicaid identification number for the individual. A copy of this completed DMAS-225 must be kept by the provider in the individual's file.

The provider must notify the LDSS via the discharge DMAS-225 and the service authorization contractor of the provider's last date-of-service delivery when any of the following circumstances occurs:

- An individual dies - include the date of death;
- An individual is discharged or discontinued from services - The date of discharge or discontinuation should be the last date services were rendered for that individual. This includes when the individual is discharged from one provider agency and admitted to another; or admitted to a nursing facility or inpatient rehabilitation facility (even for one day); and
- Any other circumstances (including hospitalization) that cause services to cease or become interrupted for more than thirty (30) consecutive calendar days. Refer to the Pre-Admission Screening Manual for requirements for updated and new screenings.

The provider must notify DMAS and request a level of care review when an individual no longer meets criteria for the services.

INDIVIDUAL ELIGIBILITY REQUIREMENTS

Eligibility Criteria

To qualify for AAL Waiver services, individuals must meet all of the following criteria:

1. The individual must be either:

- An older adult ("Elderly" as defined by § 1614 of the Social Security Act); or
- An individual with a disability ("Disabled" as defined by § 1614 of the Social Security Act).

2. The individual must meet the criteria for admission to a nursing facility as determined by a preadmission screening team using the full UAI.

3. The individual must have a diagnosis of Alzheimer's or Alzheimer's-related dementia as diagnosed by a licensed clinical psychologist or a licensed physician. The individual may not have a diagnosis of intellectual disability as defined by the American Association on Intellectual and Developmental Disabilities or a serious mental illness as defined in 42 CFR 483.102(b).

4. The individual must be receiving an Auxiliary Grant and living in or seeking admission to a safe, secure unit of a DMAS-enrolled ALF.

Enrollment

For the enrollment of all CMS-approved waiver slots, individuals will be reviewed on a first-come, first-served basis in accordance with available waiver funding. If there is no waiver slot available for an individual, the individual shall be placed on the waiting list. Individuals must meet all waiver eligibility criteria in order to be placed on the waiting list.

ADMISSION CERTIFICATION REQUIREMENTS FOR AAL SERVICES

Only providers licensed by VDSS for assisted living and enrolled with DMAS as an (AAL) waiver provider can provide publicly funded assisted living services. It is the ALF provider's responsibility to determine whether the facility can adequately provide services to an individual prior to accepting a referral. The services that the facility will provide the individual must be documented on the individual service plan (ISP).

Services will be offered only to individuals who have been certified eligible for AAL waiver services by the Pre-Admission Screening (PAS) Team or hospital discharge planner responsible for completing the pre-admission screening process for AAL waiver services. The AAL waiver provider must submit admission certification information to the DMAS Service Authorization Contractor (see Appendix D for additional information) to indicate that AAL waiver services will be provided to the individual, as documented on the ISP.

SERVICE AUTHORIZATION

Before a provider can bill DMAS for AAL Waiver services, a service authorization must be obtained from DMAS or its authorized service authorization contractor. Please refer to Appendix D of this manual for instructions regarding the Service Authorization Process.

COVERED SERVICES - 12VAC 30-120-1620

Assisted living services include personal care services, homemaker, chore, attendant care, and companion services. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

AAL Waiver services shall also include:

1. Medication administration

Medications shall be administered only by a provider employee who is currently licensed or registered to administer medications (physician, physician assistant, pharmacist, nurse practitioner, RN, LPN, other licensed health care professional (LHCP), or registered medication aide), by meeting the regulatory requirements as set forth by the DSS and the appropriate regulatory or licensing board of the Department of Health Professions in the Commonwealth.

2. Individual summaries

The LHCP must complete an admissions summary of each individual upon admission to the facility and when a significant change in health status or behavior occurs in one of the following areas: weight loss, elopements, behavioral symptoms, or adverse reactions to prescribed medication. A LHCP shall identify individual care problem areas and formulate interventions, to the extent permitted by his/her license, to address those problems and to evaluate, to the extent permitted by his/her license, if the planned interventions were successful.

3. Skilled nursing services

Skilled nursing services are nursing services that are used to complete individual summaries and administer medications, and provide training, consultation, and oversight of direct support staff. Skilled nursing services must be provided by a LHCP who is licensed to practice in the state and provided in accordance and within the scope of practice specified by state law.

4. Therapeutic social and recreational programming.

An activity program must be designed to meet the specific needs of each waiver individual and to provide daily activities appropriate to individuals with Alzheimer's or Alzheimer's related dementia.

- This program shall be individualized and properly implemented, followed, and reviewed as changes are needed.
- Waiver individuals who wander shall have an activity program to prevent this.

- Consistent with 22VAC40-72-1100, there shall be structured group activities each week, not to include activities of daily living.
- There shall be at least one hour of one-on-one activity per week, not to include activities of daily living. Such one-on-one activities may be rendered by such licensed or volunteer staff as determined appropriate by the provider.
- Group activities must be provided by staff assigned responsibility for the activities.

WAIVER WAITING LIST – 12VAC30-120-1670

DMAS shall maintain a waiting list for the purpose of individuals' access to this waiver once all of the currently approved waiver slots have been filled. Individuals must meet all waiver eligibility criteria in order to be placed on the waiting list. Individuals may be removed from the waiting list because: (1) they request that their names be removed; (2) they die; or (3) they are placed in an active slot and begin to receive services.

PROHIBITED CONDITIONS (22 VAC40-72-340)

Community or hospital assessors must determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an AAL placement. If any of these conditions are present, the assessor must document that they are present on the UAI, and the individual receiving an Auxiliary Grant is not eligible for AAL placement. State law prohibits admission or retention of individuals in an AAL when they have any of the following conditions or care needs (**bold text is used to indicate language from the *Code of Virginia***):

1. **Ventilator dependency:** A situation where a ventilator is used to expand and contract the lungs when a person is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require it in the event that they are unable to breathe on their own.

2. **Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing and care is provided by a licensed health care professional under a physician's treatment plan:** Dermal ulcers include pressure ulcers (e.g., bed sores, decubitus ulcers) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The following is a summary of dermal ulcer stages:

   Stage I — A persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved;

Stage II A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater;

Stage III A full thickness of skin loss, exposing the subcutaneous tissues (presents as a deep crater with or without undermining adjacent tissue); and

Stage IV A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

3. **Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia:** If the course of treatment extends beyond a two-week period, an evaluation by the licensed health care professional is required every two weeks.

Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein. Examples may include the infusion of fluids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parental nutrition (TPN). Intermittent intravenous therapy may be provided for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician's treatment plan.

4. **Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.**

5. **Psychotropic medications without appropriate diagnosis and treatment plans:** Psychopharmacologic or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotics, antidepressants, and the anti-anxiety/hypnotic class. Examples include, but are not limited to, Dalmane, Valium, Thorazine, Librium, Tranxene, Ativan, Xanax, Vistaril, Atarax, Restoril, Amytal, Mellaril, Haldol, and Clozaril.

6. **Nasogastric tubes:** A nasogastric tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.

7. **Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube:** Gastric tube feeding is the use of any tube that delivers food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).

8. **Individuals presenting an imminent physical threat or danger to self or others:** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the individual.

9. **Individuals requiring continuous licensed nursing care (seven days a week, twenty-four hours a day):** Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Residents requiring continuous licensed nursing care may include:

   a. Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or
   b. Individuals with a health care condition with a high potential for medical instability.

10. **Individuals whose physician certifies that placement is no longer appropriate**.

11. **Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the *State Plan for Medical Assistance* as follows: Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the UAI. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.**

12. **Individuals whose health care needs cannot be met in the specific ALF as determined by the residence**.

The ALF must plan for the discharge of any resident who has a prohibited condition. The prohibited conditions are found in the *Code of Virginia* for the Virginia Department of Social Services, § 63.2-1805 – admissions and discharges.

TERMINATION OF SERVICES – 12VAC 30-120-1610

In the case of termination of AAL Waiver services by DMAS, waiver individuals shall be notified of their appeal rights pursuant to 12VAC 30-110 – Eligibility and Appeals. DMAS may terminate AAL Waiver services for any of the following reasons:

1. The AAL Waiver is no longer required to prevent or delay institutional placement;
2. The waiver individual is no longer eligible for Medicaid;
3. The waiver individual is no longer eligible to receive an Auxiliary Grant;
4. The waiver individual no longer meets AAL Waiver criteria;
5. The waiver individual has been absent from, or has not received services from, the ALF for more than 30 consecutive days;

6. The waiver individual's environment does not provide for his health, safety, and welfare; or
7. The ALF no longer meets safe and secure licensing standards set by DSS or standards set by DMAS for service providers.

RELATION TO OTHER MEDICAID-FUNDED LONG TERM CARE SERVICES — NURSING FACILITY OR INTENSIVE INPATIENT REHABILITATION FACILITY ADMISSION

When an AAL Waiver individual is admitted to a NF, or an Intensive Inpatient Rehabilitation Facility the waiver enrollment and service authorizations are automatically terminated. Upon discharge, the AAL waiver provider must submit an enrollment DMAS-225 to the LDSS, perform a new assessment, submit a plan of care, and request a new service authorization for services (see Appendix D). Failure to request a new service authorization may result in nonpayment to the AAL waiver provider until such time as all documentation requirements are met and a service authorization has been approved. Requests for readmission must be submitted within the same timeframes as new requests. If a service authorization is not approved for all dates of service or units, providers will not be reimbursed by DMAS for denied dates/units.

The pre-admission screening for intensive inpatient rehabilitation individuals shall be completed by the local PAS Team prior to admission to community-based care services for individuals who are new to the waiver.

HOSPITALIZATION OF INDIVIDUALS

When an individual is hospitalized, the provider should contact the hospital discharge planner or hospital Social Services department to facilitate discharge planning. Information regarding transfers or plans for admission to a NF or Inpatient Rehabilitation can be obtained through discussions with the hospital discharge planner. If the individual will not be returning to community-based services, the provider must discontinue services and send a DMAS-225 to the LDSS and a discharge request to the service authorization contractor that indicates the individual's last date of service with the provider.

SUSPECTED ABUSE OR NEGLECT

If the provider suspects that an AAL Waiver individual is being abused, neglected, or exploited, or is at risk for abuse, neglect or exploitation, Virginia law (*Code of Virginia*, §63.2-1606) mandates that the party having knowledge or suspicion of the abuse, neglect, and/or exploitation, immediately make a report to either the LDSS where the individual resides or to the toll-free, 24-hour APS hotline AT:

APS: 1-888-83-ADULT (1-888-832-3858)

RELATION TO OTHER MEDICAID-FUNDED HOME CARE SERVICES

Virginia currently offers two other home-based (non-waiver) services through the Virginia *State Plan for Medical Assistance*: home health and hospice care that may be used to support the individual's care needs while in the AAL waiver.

Home Health

AAL waiver providers must provide for certain services as mandated by the VDSS licensing standards for ALFs found at 22VAC40-72-10 et seq. When the ALF must provide home health nursing or aide services as a component of these covered services, DMAS will not reimburse a home health agency to provide such services to residents of AAL Waiver ALFs. The ALF must provide the services as specified below, and the home health agency cannot bill DMAS for any of the specified non-reimbursable services. Prior to accessing home health services, the ALF must contact the individual's Primary Care Physician for a referral. If the individual is enrolled in a Managed Care Organization (MCO) plan, the ALF should contact the MCO and follow the appropriate MCO guidelines for referrals.

The home health services that must be provided by the ALF and are not billable to DMAS or the individual are:

- Home health aide services;
- Medication administration, including but not limited to:
  - By-mouth (oral) administration,
  - Insulin injections,
  - Eye drops,
  - Rectal administration,
  - Topical application,
  - Inhalers, and
  - Nasal administration.
- Medication monitoring; and
- Superficial wound care for pressure ulcers up to stage I-II or care to skin tears, minor cuts, or abrasions.

When injections other than insulin are necessary and ordered by the physician, the ALF must either administer the injection by appropriately licensed staff or assist the individual by securing the injection services through a home health agency, through an outpatient clinic visit, or through emergency services as most appropriate for the medical circumstance and reimbursement guidelines.

If a home health provider bills for or has billed for any of these services for an individual residing in an ALF, DMAS will deny or retract reimbursement for the inappropriate payments for such services.

In some cases, it may be appropriate for home health skilled nursing to be offered to individuals residing in ALFs. These cases only include services the ALF is not required to provide. Services requiring professional skills (such as tube feedings, Foley catheter

irrigations, sterile dressings, or any other procedures requiring sterile technique) cannot be performed by ALF staff. The skilled nursing care provided to the individual shall not be for prohibited conditions as defined by the VDSS regulations and described previously in this chapter.

Medicaid may cover skilled nursing services provided by a home health agency for less than 30 days. Personal care services provided by a home health agency will not be reimbursed. Medicaid cannot be billed for a home health aide and ALF staff providing identical services to the same individual at the same time.

The above clarifications regarding the home health program are specific to home health nursing services and aide services only. Individuals residing in ALFs are eligible for home health rehabilitation therapies (i.e., physical therapy, occupational therapy, and/or speech-language pathology services) as long as the appropriate reimbursement criteria are met.

Hospice Care

The AAL waiver provider must contact DMAS prior to initiating service for any individual who is receiving hospice services. Prior to accessing hospice services, the ALF must contact the Primary Care Physician for a referral. Hospice is an autonomous, centrally administered, and medically directed program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill individual and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available, thereby avoiding institutionalization. To be covered, hospice services must be elected by the individual, and his or her terminal illness (prognosis of six months or less) must be certified by the individual's attending physician and the hospice medical director. A hospice must routinely provide a core set of services, which include nursing care, physician services, social work, and counseling. For additional information and covered hospice services, refer to the Department of Medical Assistance Services Hospice Manual, which can be found on the DMAS web portal at www.virginiamedicaid.dmas.virginia.gov

CHANGE OF RESIDENCE

If an individual's residence changes, the provider must record this in the individual's record and notify the LDSS immediately and in writing. The AAL waiver provider is required to notify the LDSS via the DMAS-225. The AAL waiver provider is also required to notify DMAS' service authorization contractor of any discharges from the AAL waiver program.

INDIVIDUALS WITH COMMUNICABLE DISEASES

Current information regarding the transmission of HIV and Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing support to individuals in their homes.

Certain routine hygienic precautions designed to prevent the spread of all communicable diseases, including blood borne infections, should be taken by all providers when rendering support to any individual, regardless of his/her known medical condition. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after providing care for each individual.

Providers are prohibited from discriminating against individuals who have been diagnosed as having Human Immunodeficiency Virus (HIV)/AIDS and other communicable diseases.