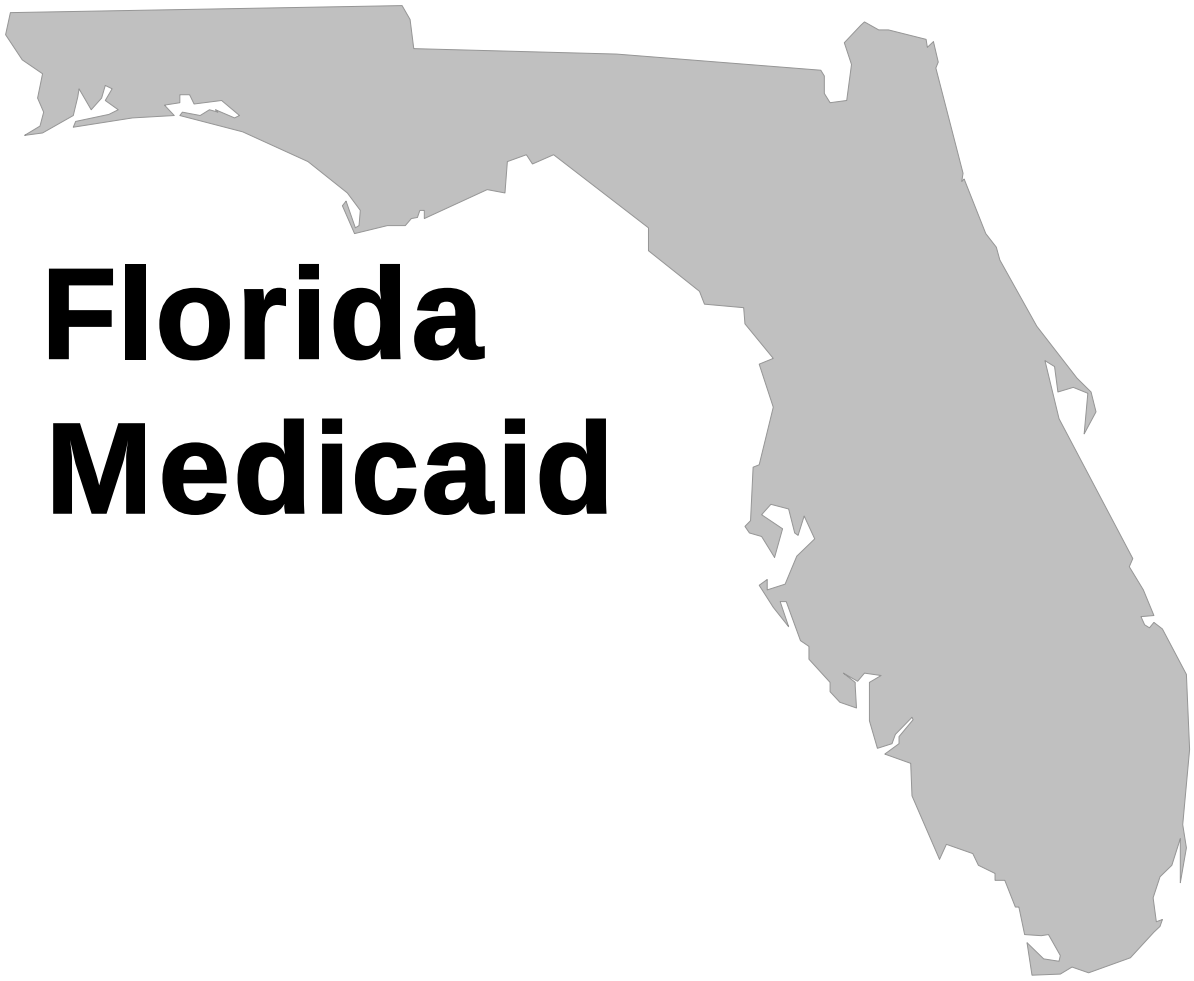

Florida Medicaid

Project AIDS Care Waiver Services Coverage & Limitations Handbook

Agency for Health Care Administration

FLORIDA MEDICAID

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

May 10, 2006

Dear Medicaid Provider:

Enclosed please find update December 2005 to the Florida Medicaid Project AIDS Care Waiver Services Coverage and Limitations Handbook. The handbook update revises the eligibility criteria to allow recipients who are enrolled in a Medicaid HMO that is contracted as part of the 1915(b) HIV/AIDS Specialty Waiver to receive PAC waiver services. The handbook update also contains the new procedure code for PAC waiver pest control services that was effective January 2005.

The following pages in the handbook have been updated.

Updated Pages
Update Log
Chapter 2, page 2-3
Appendix A
Appendix K, page K-3

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at http://ahca.myflorida.com. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Florida Medicaid Provider Handbook and Resource Library CD-ROM and on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then on Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder, Chief
Bureau of Medicaid Services

UPDATE LOG
PROJECT AIDS CARE WAIVER SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
July 2003—New Handbook	July 2003
Jan2005—Replacement Page	January 2005
Dec2005—Replacement Page	December 2005

PROJECT AIDS CARE WAIVER SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

Appendices

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.
Note	Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update No.” and the “Effective Date”.

Handbook Updates, continued

How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following: 1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced. 2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update. 3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.
Numbering Update Pages	Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)
Effective Date of New Material	The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date. If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.
Identifying New Information	New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label	A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.
New Label and New Information Block	A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.
New Material in an Existing Information Block	New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.
New or Changed Paragraph	A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph. Paragraph with new material.

CHAPTER 1
PROJECT AIDS CARE WAIVER SERVICES
PROVIDER QUALIFICATIONS AND PROVIDER ENROLLMENT

Overview

Introduction

Chapter 1 specifies the legal authority for the Florida Medicaid Project AIDS Care (PAC) Waiver Program, and describes the purpose of the program, the provider qualification requirements and the provider enrollment process.

In This Chapter

This chapter contains:

Purpose and Description

Handbook

The PAC Waiver Services Coverage and Limitations Handbook is intended as a resource for case management agencies and service providers in the day-to-day delivery of PAC waiver services. The handbook describes policies and procedures that the provider must comply with in order to meet federal and state regulations.

The PAC Waiver Services Coverage and Limitations Handbook must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, which describes how to complete and file claims for reimbursement by Medicaid, and the Florida Medicaid Provider General Handbook, which describes general Medicaid policies.

Purpose and Description, continued

Brief Description of the PAC Waiver Program

The purpose of the PAC waiver is to promote, maintain, and optimize the health of persons living with AIDS in order to delay or prevent institutionalization. PAC waiver provides home and community-based services to Medicaid eligible persons with a documented diagnosis of AIDS (Acquired Immune Deficiency Syndrome) that choose to live at home and in the community.

Recipients of PAC waiver services must demonstrate health conditions, such as the presence of AIDS related opportunistic infections, and limitations in functioning that cause them to be at risk of hospitalization or placement in a nursing facility, were it not for the provision of PAC waiver services.

Legal Authority for the PAC Waiver Program

Medicaid Home and Community-Based Services (HCBS) Waiver Programs are authorized under section 1915(c) of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Part 441.300.

The Florida Medicaid Project AIDS Care Waiver is authorized by Chapter 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

Administrative Responsibilities

The PAC Waiver Program is administered by the Agency for Health Care Administration (AHCA), Division of Medicaid, in collaboration with the Department of Elder Affairs (DOEA) and the Department of Children and Families (DCF).

- DCF is responsible for determining financial eligibility for Medicaid and the PAC waiver.
- DOEA, Comprehensive Assessment and Review of Long Term Care Services (CARES) unit, is responsible for determining the level of care for individuals who are at risk of hospitalization, or at risk of placement in an institution or nursing facility.
- AHCA is responsible for the:
  - ⇒ Operation of the PAC waiver program;
  - ⇒ Monitoring of the program in accordance with federal requirements;
  - ⇒ Development of waiver policy; and
  - ⇒ Reimbursement of authorized waiver services provided.

Purpose and Description, continued

PAC Waiver Services

The PAC Waiver Program reimburses for the following services:

- Case Management
- Chore – Pest Control and Other
- Day Health
- Education and Support
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Homemaker
- Personal Care
- Restorative Massage
- Skilled Nursing – RN and LPN
- Specialized Medical Equipment and Supplies
- Specialized Personal Care for Foster Care Children
- Therapeutic Management of Substance Abuse.

Provider Qualifications

Introduction

PAC waiver service providers must be enrolled:

- In Medicaid and meet the general provider qualifications that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook; and
- As a home and community-based services PAC waiver provider by meeting provider qualifications for the waiver-specific service as listed in this handbook.

PAC Waiver Case Management Agency Qualifications

PAC waiver case management agencies must meet general Medicaid provider qualification standards in addition to qualifications listed in this handbook.

A PAC waiver case management agency must be licensed under Chapter 395, F.S. and have demonstrated a minimum of two years experience case managing persons diagnosed with HIV/AIDS.

PAC waiver case management services can be provided by the following entities:

- Department of Health, County Health Departments, in accordance with Chapter 395, F.S.;
- Department of Health, Children's Medical Services (CMS), in accordance with Chapter 395, F.S.;
- Hospitals licensed by AHCA, Division of Health Quality Assurance (HQA), in accordance with Chapter 395, F.S.;

Provider Qualifications, continued

PAC Waiver Case Management Agency Qualifications, continued

- Federally Qualified Health Centers (FQHC) in accordance with Chapter 395, F.S. that are approved as Early Intervention Services (EIS) Ryan White Title III grantees and provide optional HIV case management services under that grant; and
- AIDS Community-Based Organizations.

Case Management Agency Requirements

To provide Medicaid PAC waiver case management services, a case management agency (CMA) must:

- Have sufficient numbers of qualified case management staff, support staff, and administrative staff to meet the demand for services;
- Have a case management supervisor who holds a minimum of a bachelor's degree in a social science or health field and has a minimum of two years experience in case management, one of which must be in AIDS-related services;
- Have case management caseloads that do not exceed 75 PAC waiver cases per full-time equivalent PAC waiver case manager;
- Be culturally sensitive and have the ability to communicate in the language appropriate to the community served;
- Have demonstrated capability and experience in developing and implementing outreach strategies designed to inform and prevent the spread of HIV/AIDS;
- Have demonstrated capability and experience in provider network development;
- Conduct provider training and follow up on service delivery;
- Have data collection and analysis capabilities that enable the tracking of consumer service utilization, cost and demographic information;
- Have written quality assurance policies and a continuing internal quality improvement program;
- Have accounting records that meet generally accepted accounting principles and are in sufficient detail to constitute a clear audit trail to justify Medicaid reimbursement for PAC waiver services;
- Comply with federal civil rights and handicapped statutes;
- Practice confidentiality procedures and safeguards;
- Observe policies that prevent conflict of interest;
- Maintain an organizational chart with position descriptions including educational requirements and minimum qualifications;
- Follow case management procedures and protocols; and
- Conduct case manager training and continuing education.

***Provider Qualifications**,* continued

AIDS Community Based Organization (CBO) Requirements

To provide PAC waiver case management services, an AIDS Community-Based Organization (CBO) must be organized for the primary purpose of providing health, social, or support services to persons with HIV/AIDS.

In addition, the CBO must meet all case management agency qualifications stated above and must:

- Be organized as a not-for-profit corporation in Florida and have IRS 501(c)(3) certification;
- Have a board of directors consisting of at least five members that meet quarterly;
- Have written policies and procedures approved by the board of directors governing:
  - ⇒ Compliance with federal civil rights and handicapped statutes;
  - ⇒ Confidentiality procedures and safeguards;
  - ⇒ Conflict of interest prohibitions;
  - ⇒ Fiscal operations and oversight;
  - ⇒ Position descriptions including educational requirements and minimum qualifications;
  - ⇒ Case management procedures and protocols; and
  - ⇒ Case manager training and continuing education.
- Have a full-time administrator who holds a minimum of a bachelor's degree from an accredited college or university in a social sciences or health field, and has a minimum of two years of health or human services management experience, one of which must be in AIDS-related services.

***Provider Qualifications**,* continued

Case Manager	A PAC waiver case manager must be enrolled with Medicaid as an individual treating provider associated with a PAC waiver case management agency's group provider number. Case managers must be certified by the Department of Health to have successfully completed the HIV/AIDS 101 Education Program and meet one of the following qualifications: • Have a bachelor's degree in a social science or health field; • Have four years of verifiable experience case managing individuals with HIV/AIDS at an established agency that can substitute on a year-for-year basis for a bachelor's degree; • Have a bachelor's degree in a field other than social science or health and have a minimum of one year of case management experience; • Be a registered nurse without a bachelor's degree who has a minimum of one year of case management experience; or • Be a licensed practical nurse without a bachelor's degree that has a minimum of three years of case management experience.
Chore Services	To provide Medicaid PAC waiver chore services, providers must be independent private vendors with occupational licenses issued by the local governing authority in accordance with Chapter 205, F.S., and hold a certificate that documents successful completion of the Department of Health's HIV/AIDS 101 Education Program.
Chore – Pest Control Services	To provide Medicaid PAC waiver chore – pest control services, providers must be pest control businesses licensed by the Department of Agriculture and Consumer Services in accordance with Chapter 487, F.S.
Day Health Services	To provide Medicaid PAC waiver day health services, providers must be: • Adult day care centers licensed by HQA in accordance with Chapter 400, F.S.; • Child day care centers licensed by the DCF in accordance with Chapter 402, F.S.; or • Prescribed pediatric extended care (PPEC) providers licensed by HQA in accordance with Chapter 391, F.S., and Chapters 16 and 59, F.A.C.

Provider Qualifications, continued

Education and Support	To provide Medicaid PAC waiver education and support services, providers must be: • Psychologists licensed by Medical Quality Assurance (MQA) in accordance with Chapter 490, F.S.; • Mental Health Counselors licensed by MQA in accordance with Chapter 491, F.S.; • Clinical Social Workers licensed by MQA in accordance with Chapter 491, F.S.; • Marriage and Family Therapists licensed by MQA in accordance with Chapter 491, F.S.; or • Medicaid-enrolled community mental health providers.
Environmental Accessibility Adaptation	To provide Medicaid PAC waiver environmental accessibility adaptation services, providers must be: • Contractors licensed by the Department of Business and Professional Regulation (DBPR) in accordance with Chapter 489, F.S.; or • Independent vendors with an occupational license issued by the local governing authority in accordance with Chapter 205, F.S., who have obtained an HIV/AIDS training certificate issued by AHCA or the Department of Health.
Home-Delivered Meals	To provide Medicaid PAC waiver home-delivered meals, providers must have a minimum of two years experience (effective July 1, 2004) in home delivered meals service and be: • Meal preparation and delivery businesses licensed by DBPR, in accordance with Chapter 509, F.S.; the Department of Agriculture and Consumer Services, in accordance with Chapter 500, F.S.; or the Department of Health, in accordance with Chapter 381, F.S.; or • Restaurants licensed by DBPR, in accordance with Chapter 509, F.S.; the Department of Agriculture and Consumer Services, in accordance with Chapter 500, F.S.; or the Department of Health, in accordance with Chapter 381, F.S.; or • Federal Older Americans Act providers contracted for home delivered meals.

Provider Qualifications, continued

Homemaker	To provide Medicaid PAC waiver homemaker services, providers must be: • Homemakers, sitters, companions registered with HQA in accordance with Chapter 400, F.S., who hold a certificate that documents successful completion of the HIV/AIDS 101 Education Program developed by the Florida Department of Health; • Home health agencies licensed by HQA in accordance with Chapter 400, F.S.; or • Hospice agencies licensed by HQA in accordance with Chapter 400, F.S.
Personal Care	To provide Medicaid PAC waiver personal care services, providers must be: • Home health agencies licensed by HQA in accordance with Chapter 400, F.S.; • Hospice agencies licensed by HQA in accordance with Chapter 400, F.S. or • Nurse registries licensed by HQA in accordance with Chapter 400, F.S.
Restorative Massage	To provide Medicaid PAC waiver restorative massage services, providers must be: • Massage therapists licensed by DBPR in accordance with Chapter 480, F.S.; or • Physical therapists licensed by MQA in accordance with Chapter 486, F.S.
Skilled Nursing	To provide Medicaid PAC waiver skilled nursing services, providers must be: • Home health agencies certified and licensed by HQA in accordance with Chapter 400, F.S.; or • Hospice agencies licensed by HQA in accordance with Chapter 400 F.S.

Provider Qualifications, continued

Specialized Medical Equipment and Supplies	To provide Medicaid PAC waiver specialized equipment and supplies services, providers must be: • Medical supplies companies licensed in accordance with Chapter 205 F.S. • Home health agencies licensed by HQA in accordance with Chapter 400, F.S.; • Hospice agencies Medicare-certified and licensed by HQA in accordance with Chapter 400, F.S.; • Pharmacies licensed by MQA in accordance with Chapter 465, F.S.; or • Medicaid-enrolled durable medical equipment providers.
Specialized Personal Care for Foster Children	To provide Medicaid PAC waiver specialized personal care for foster care children services, providers must be: • Foster homes licensed by DCF in accordance with Chapter 409 F.S.; or • Shelter care homes licensed by DCF in accordance with Chapter 409 F.S.
Therapeutic Management of Substance Abuse	To provide Medicaid PAC waiver therapeutic management of substance abuse services, providers must be Medicaid-enrolled community mental health providers licensed by the DCF in accordance with Chapter 397, F.S.

Provider Enrollment

General Enrollment Requirements

PAC waiver providers must meet general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, PAC waiver providers must meet the specific enrollment requirements that are listed in this section.

Enrollment Process

Applicants are required to submit the current version of the Medicaid Provider Application, AHCA Form 2200-0003, which is incorporated by reference in 59G-5, F.A.C.

Provider enrollment application packages can be downloaded from the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. They may also be requested from the fiscal agent's Provider Support Services toll free number 800-377-8216.

Where to Submit Enrollment Packages

Submit completed enrollment applications to AHCA Medicaid headquarters office at:

Agency for Health Care Administration
Medicaid Services, PAC Waiver/LTC&BH Unit
2727 Mahan Drive, Building 3, MS# 20
Tallahassee, Florida 32308

Effective Date of Enrollment

Enrollment of a Medicaid provider applicant is effective no earlier than the date of the approval of the provider application.

An "approved application" is an accurately and fully completed application including background screenings and onsite inspections resolved and completed with approval of AHCA or its designee, in accordance with Chapter 59G-5, Florida Administrative Code, and section 409.907, F.S.

Provider Enrollment, continued

Medicaid Office Responsibilities

The Medicaid PAC waiver headquarters staff are responsible for:

- Reviewing the enrollment package and requesting additional supporting information or documentation, if needed.
- Certifying that the provider meets the qualifications to provide specific PAC waiver services.
- Submitting the enrollment package and certification to the Medicaid fiscal agent.

Medicaid Fiscal Agent Responsibilities

The fiscal agent notifies the provider of the provider number(s) and the effective date of enrollment.

Provider Groups

Two or more providers whose practice is incorporated under the same tax identification number must enroll as a Medicaid provider group.

In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

The group must have unique location codes for each location in which a group member practices as described below.

The Medicaid fiscal agent will assign the group a nine-digit group provider number.

If the group is already enrolled as a group provider for another Medicaid service, the fiscal agent will assign a two-digit location code (the last two digits of the provider number).

To receive Medicaid reimbursement, the group must enter this number as the pay-to-provider number on the Medicaid claim form.

Provider Enrollment, continued

Individual Treating Providers

The case management agency staff that provides case management services must be enrolled as individual treating providers.

The Medicaid fiscal agent will assign each individual treating provider in the group a nine-digit provider identification number to identify the person who actually performs the service.

To receive Medicaid reimbursement, the group must enter this nine-digit provider identification number as the treating provider on the Medicaid claim form.

Note: See Chapter 1 in the Medicaid Provider Reimbursement Handbook, Non-Institutional 081, for additional instructions on entering the provider number on the claim form.

Multiple Locations and Location Codes

Both individual and group providers who have practices at more than one location, i.e., satellite office, must have separate location codes for each practice location.

Providers must use the location code assigned to the practice location when billing for services provided at the location.

The provider must notify the area Medicaid office of additional practice locations. Notification must be made on an Application for a New Location Code, and include an effective date for the new location.

Closure of a practice location must be reported to the Medicaid fiscal agent and the area Medicaid office, along with the effective date of the closure.

Service Provider Sub-Contracting Responsibilities

A PAC Waiver service provider is responsible for its employees and contractees maintaining compliance with the terms of the provider agreement. The provider and subcontractors must comply with policies in the Florida Medicaid Provider General Handbook and the PAC Waiver Services Coverage and Limitations Handbook.

Provider Responsibilities

Group Provider Responsibilities

Providers must notify Medicaid headquarters when PAC waiver case management staff, enrolled as individual treating providers, are no longer employed by the group. Send notification to:

Agency for Health Care Administration
Bureau of Medicaid Services
2727 Mahan Drive, Building 3, MS# 20
Tallahassee, Florida 32308
Attn: Program Administrator, PAC Waiver/LTC&BH Unit

Case Managers

Case managers that provide the case management services must be enrolled as individual treating providers and be employed by an enrolled case management agency. A case manager can provide management to a maximum of 75 PAC waiver recipients.

Staffing Responsibilities

A PAC waiver provider must furnish sufficient and qualified staff to meet the needs of individuals enrolled in the PAC Waiver Program, with a minimum of one case manager for 75 PAC waiver recipients.

Staffing requirements must be based on the amount and type of services provided to consumers as authorized in plans of care and in accordance with consumer service needs documented in the needs assessment.

HIPAA Requirements

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003.

This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

CHAPTER 2
PROJECT AIDS CARE WAIVER SERVICES
COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the requirements for service provision, service limitations and exclusions under the Florida Medicaid Project AIDS Care (PAC) Waiver Program.

In This Chapter

This chapter contains:

Service Requirements

Introduction

Medicaid reimburses home and community-based waiver services provided to recipients enrolled in the PAC waiver. The services must be medically necessary and needed to prevent or delay the progression of the disease, resulting in hospitalization or institutionalization of the recipient.

Services provided under the waiver may not duplicate services provided through other funding sources including services covered by the Medicaid State Plan.

Medicaid Eligibility

The Department of Children and Family Services (DCF) determines financial eligibility for home and community-based waiver services by using income and assets standards for Supplemental Security Income (SSI), MEDS-AD or the Institutional Care Program (ICP).

Applicants who are not Medicaid eligible must be referred to DCF to apply for assistance.

Individuals that qualify for Medicaid under MEDS-AD must also apply for disability benefits from the Social Security Administration office. Individuals whose applications have been denied have the right to appeal the decision.

Medically Needy

Individuals eligible for Medicaid under the Medically Needy Program are not eligible for PAC waiver services. Providers must verify Medicaid eligibility for PAC waiver services on a monthly basis to avoid denial of claims.

Level of Care Determination for Risk of Hospitalization or Placement in a Nursing Facility (Appendix C)

The Department of Elder Affairs (DOEA), Comprehensive Assessment and Review of Long Term Care Services (CARES) unit, determines the applicant's level of care (LOC). The level of care determination verifies that an individual is at risk of hospitalization or nursing facility placement without the provision of PAC waiver services.

The level of care determination is initiated by the case manager on receipt of a completed Physician Referral and Request for Level of Care Determination, CARES Form 607. The physician, based on the patient's medical history and current condition, certifies that the individual is disabled and might require hospitalization in the absence of home and community based services.

DOEA/CARES documents the level of care determination on the same form. All PAC waiver recipients must have a signed and dated determination of level of care and an effective date. PAC waiver services will not be reimbursed prior to the effective date of the level of care.

A recipient's level of care must be re-evaluated annually by CARES nursing staff and the determination documented in the recipient's case record.

Note: See Appendix C for a copy of the Physician Referral and Request for Level of Care Determination, CARES Form 607.

Service Requirements, continued

Eligibility Criteria and Who Can Receive PAC Waiver Services

Individuals receiving PAC waiver services must meet the following eligibility criteria:

- Documented diagnosis of AIDS by a physician;
- Presence of AIDS related opportunistic infections;
- Medicaid eligible under Supplemental Security Income (SSI), MEDS-AD or the Institutional Care Program (ICP);
- Determined by CARES to be at risk of hospitalization or institutionalization in a nursing facility;
- Determined disabled according to Social Security Administration standards;
- Not be enrolled in a Medicaid HMO except one contracted as part of the 1915(b) HIV/AIDS Specialty Waiver;
- Not be enrolled in any other Medicaid waiver program;
- Capable of remaining safely in the home and community;
- Need and receive PAC waiver case management services; and
- Have completed, signed and dated a PAC Waiver Enrollment Application as described below.

PAC Waiver Enrollment Application (Appendix B)

The recipient or designated representative must complete, sign and date a PAC Waiver Enrollment Application.

The PAC Waiver Enrollment Application must be filed in the case manager's case record for the recipient.

Note: See Appendix B for a copy of the PAC Waiver Enrollment Application.

Case Management Requirements

Description

Case management is a PAC waiver service that enables recipients to obtain access to needed medical and social support services regardless of the funding source. Case management identifies, organizes, coordinates and monitors services needed by the recipient.

Case Manager Requirements

Every PAC waiver recipient must have a Medicaid-enrolled PAC waiver case manager who is employed by a Medicaid-enrolled PAC waiver case management agency.

PAC waiver case management is reimbursed at a flat monthly fee as described in Chapter 3, PAC Waiver Procedure Codes and Fees.

Case management can only be reimbursed for the months that have documented case management activity in the case record.

Case management cannot be reimbursed when there is no case management activity for longer than one calendar month when a recipient is in:

- A hospital or institution;
- A nursing home;
- A residential treatment program;
- Prison.

Case management cannot be reimbursed if the recipient is not receiving case management services and the case manager has not had the minimum direct contact with the recipient that is required by the recipient's acuity level. Examples of activities that are not considered direct contact are unanswered phone calls, voice messages, e-mails, greeting cards or other mail, and home visits when the recipient is absent.

Note: Refer to the Acuity Levels and PAC Waiver Services table in Appendix I.

Case Management Requirements, continued

Case Manager Responsibilities

The case manager is responsible for performing and documenting the following activities.

- Home visits to complete face-to-face Comprehensive Needs Assessments and identify functional and social service needs of the recipient.
- Coordinate the completion of Medical Needs Assessment and Acuity Level Determination by the nurse care manager from the disease management organization.
- Periodic face-to-face reassessments.
- Develop and update plans of care based on the recipient's acuity level in consultation with the recipient, caregiver, the physician's office, CARES staff, disease management organization nurse and other relevant parties.
- Provide updated copies of the plan of care to the recipient and the disease management organization nurse.
- Coordinate efforts to access services provided by all funding sources including Medicaid and non-Medicaid sources.
- Provide completed service authorizations to providers for services in the plan of care.
- Follow up with the recipient and the provider to monitor the quality, quantity, duration and effectiveness of the services provided.
- Maintain documentation for all services authorized and any follow up activity.
- Submit exception requests to the disease management organization nurse for services that are needed, but are not included under the recipient's assessed acuity level.
- Maintain required face-to-face and telephone contacts with the recipient as described in the Acuity Levels and PAC Waiver Services table, Appendix I.
- Advocate for the needs of the recipient. The case manager can assist a recipient who requests a fair hearing by contacting the local office of Economic Self Sufficiency, DCF or the Office of Appeal Hearings, Building 5, #203, 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700, phone: 850-488-1429.
- Maintain updated, signed, dated and legible case notes that document the changing needs and welfare of the recipient.
- Follow the PAC Waiver Assessment and Case Management Protocol.
- Protect the privacy and confidentiality of the recipient.

Case Management Requirements, continued

Services that are not Reimbursable under PAC Waiver Case Management

Services that are not reimbursable under PAC waiver case management are:

- Services by a case manager not enrolled in Medicaid;
- Claims for dates of service after a case manager has left the employment of the agency;
- Services provided by a case manager who does not meet PAC waiver qualifications;
- Services provided that are not in the current plan of care;
- Services that are hands-on medical or clinical in nature;
- Counseling services;
- Transportation services;
- Distribution of seasonal greetings and gifts; and
- Duplicative case management services provided to the same recipient for coordinating access to the same services.

Case Management Documentation

Case Records

Case managers must develop and maintain case records for every recipient receiving PAC waiver services. A case record must be maintained in a single location to promote continuity and quality of care. The case record is the basis for quality assurance monitoring and must contain information regarding case management, the recipient's condition and service provision.

Confidentiality

Case records must be maintained by the case management agency at a secured central location to ensure the confidentiality of recipient information.

Essential Elements of Case Note Entries

The following are essential elements required in a case record entry:

- Name and date(s) of service;
- Location of service;
- Name of provider, type of service, duration and units of service;
- A description of the recipient's need for the service, the benefit to the recipient and anticipated outcomes;
- Plans to follow-up on the service, goals and outcomes;
- Explanations that describe efforts to access services through all funding sources; and
- The case manager's legible signature and date in the margin of all case notes including hard copies of computerized notes.

Case Management Documentation, continued

Case Note Examples

Case notes that provide sufficient detail of an acceptable case management activity must contain the essential elements, a brief description of the activity and how it benefits the recipient. Following are examples of acceptable and unacceptable case notes:

- Acceptable: An office-visit (location) by client on (date) to discuss health status. Client agrees to address depression or substance abuse issues. The plan of care was reviewed and updated. Appointments set with (Provider Name) for (units) from (date) to (date) etc. Anticipate (service) will help client cope with anxieties.

  Copy of plan of care given to client and faxed to nurse care manager. Service authorization mailed to (Provider). Follow up on appointment on (date). (Any circumstances that will help the case manager follow up in future can be included.) A total of two hours was spent coordinating these services. Sign and date the entry legibly.

- Unacceptable: "Office visit for two hours to discuss improved health and problem with landlord." This is too brief.

  A lengthy two-page anecdotal description of the conversations and circumstances if not relevant to the issue may be unnecessary and considered inadequate documentation.

Case Record Components

The case record must contain the following completed documents:

- A signed and dated PAC Waiver Enrollment Application (Appendix B);
- Copies of Medicaid eligibility documents, for example the Notice of Case Action from the Department of Children and Families, including current re-certifications;
- Level of care determination notices (Appendix C) from the Department of Elder Affairs/CARES unit and annual level of care updates;
- Documentation from the physician of an AIDS diagnosis;
- Documentation of AIDS-related opportunistic infections;
- Comprehensive needs assessments and reassessments: social assessment (Appendix D) and medical assessment (Appendix E);
- Acuity level determined by the disease management organization and recommended PAC waiver Services (Appendix I);
- Plans of care and the Plan of Care Summary form (Appendix F);
- Service authorizations for PAC waiver services (Appendix G);
- Exception request approvals (Appendix H) for services that exceed maximum limits;
- PAC Waiver Case Management Agency Transfer Request, if applicable (Appendix J);
- Case notes describing case management activity related to coordination of services and the recipient's welfare.

Case Management Documentation, continued

Computerized Case Notes

Medicaid requires that providers retain medical, fiscal, professional and business records on all services. In order to qualify as a basis for reimbursement, the records must be signed and dated at the time of service, or otherwise attested to as appropriate to the media. Stamped signatures must be initialed. Computer entries must be signed and dated by the case manager.

Case management agencies must implement written policies that ensure the safety and confidentiality of recipient records.

Permanent Record Documentation for a Minimum of 5 Years

All case record documentation (including the case narrative) must be in ink and must be legible. No erasures or "white out" are permitted. In case of an error or changes to case record documentation, the case manager lines through the entry, initials and dates it, and then makes the revised entry.

Case narrative entries must be signed and dated by the case manager.

All case record documentation and narrative must be maintained in a secure location to protect the confidentiality of the recipient.

All case record documentation must be maintained by the case management agency and be available on request for a minimum of five years.

Note: See Chapter 2 of the Medicaid Provider General Handbook for additional information about documentation requirements.

Intake and Completing the PAC Waiver Enrollment Application (Appendix B)

A PAC Waiver Enrollment Application (Appendix B) must be completed, signed and dated by the recipient or designated representative, prior to the authorization of PAC waiver services. The application must be filed in the case record.

The case manager is responsible for explaining to the recipient and documenting in the case record:

- The participant's rights and responsibilities.
- The choice to receive services in an institution (nursing home or hospital) or in the home.
- The choice to enroll with a PAC waiver case management agency from a list of available agencies in the area.

The case manager must document in the case narrative the date when intake was completed. The signed documents must be filed with the completed PAC Waiver Enrollment Application in the case record.

Comprehensive Needs Assessment

Comprehensive Needs Assessment

When a referral is received by a case management agency, the PAC waiver case manager must contact the applicant and the Disease Management Organization (DMO) nurse care manager (RN) to arrange for a face-to-face home visit to complete an initial comprehensive needs assessment of the person's medical and social needs.

The PAC waiver case manager and the nurse care manager must try to coordinate the home visit for the same time, to limit the inconvenience to the recipient.

The home visit must be conducted within five working days from the date of enrollment in the PAC waiver. When not possible, the case manager must schedule the visit for the earliest available date and document the reasons in the case notes.

The comprehensive needs assessment is comprised of two parts:

- Medical needs assessment and
- Social needs assessment.

Social Needs Assessment by Case Manager (Appendix D)

The case manager must complete an initial social needs assessment that evaluates the recipient's current condition, the living environment, availability of social supports, and identifies service needs that will help prevent institutional placement. The case manager may speak with the recipient, the recipient's formal and informal caregivers or any designated representative.

The case manager must make a face-to-face home visit to complete the needs assessment. The services recommended in the recipient's plan of care must be based on the social and medical needs assessments.

The social needs assessment must be completed by using the Project AIDS Care Waiver: Level of Need (LON) Assessment Case Management Tool. The social needs assessment must be signed and dated by the case manager. The document must be filed in the recipient's case record.

Note: See Appendix D for a copy of the Project AIDS Care Waiver: Level of Need (LON) Assessment Case Management Tool.

Comprehensive Needs Assessment, continued

Medical Needs Assessment by the DMO Nurse Care Manager (Appendix E)

When the DMO receives a referral from the PAC waiver case manager, a nurse care manager will work with the case manager to schedule an initial visit to the recipient's home at the same time. The care manager will assess the needs of the recipient and complete the medical needs assessment form.

The medical needs assessment must be completed by using the PHC Initial Care Management Assessment. The medical needs assessment document must be signed and dated by the care manager. The document must be filed in the recipient's case record.

Note: See Appendix E for a copy of the medical assessment tool.

Determination of Acuity Levels (Appendix I)

Based on the findings of the comprehensive needs assessment, the care manager will recommend that the recipient be placed in an acuity level ranging from Level I - Low Acuity, to Level II - Moderate Acuity, or Level III - High Acuity.

PAC waiver services will be available to the recipient based on the acuity level designated by the care manager in accordance with the Acuity Levels and PAC Waiver Services chart in Appendix I. The maximum limits for each service is listed in Appendix A. The case manager can submit an exception request (Appendix H) when a recipient needs a service that is not included under an acuity level, or is needed in excess of the maximum limits.

At minimum, a Medical Needs Assessment is performed:

- Initially at enrollment, and
- Annually at the end of the year of enrollment.

The case manager may request an unscheduled medical or social re-assessment due to changes in circumstances or the health of the recipient. A change to the acuity level can only be authorized by the care manager after a medical reassessment is completed.

Note: See Appendix I for a copy of the Acuity Levels and PAC Waiver Services chart.

Comprehensive Needs Assessment, continued

Contents of the Social and Medical Needs Assessment Documentation

The comprehensive social and medical needs assessment must, at a minimum, contain the following information which will be used in planning the care of the recipient:

- Health information, including medical history and substance abuse if any;
- Current health status, nutritional status and mental health status;
- Current functional capacity, including the evaluation of the recipient's ability to perform activities of daily living;
- Support systems including formal care received and support provided by informal caregivers;
- Living conditions, living arrangements, household composition, assessment of environmental conditions, tenant or owner; and
- Financial resources.

The social and medical needs assessments must be kept in the recipient's case record as separately identifiable documents. All contacts and visits made in completing the assessment must be noted in the case narrative.

Plan of Care

Description

A plan of care is a written document that describes the service needs of a recipient, the services to be provided, the name and Medicaid identification number of the provider, frequency of the services to be provided, the duration of the services and the estimated cost. The case manager must consult the recipient, the designated representative, the caregiver, the physician's office and the care manager while completing the plan of care.

The plan of care is based on a review of the completed social needs assessment, the medical needs assessment and the CARES Form 607, Physician Referral and Request for Level of Care Determination. The information gathered through these instruments is used by the case manager to establish the recipient's plan of care, and to identify both waiver and non-waiver services that are required to maintain the recipient in the community and reduce functional limitations in order to avoid hospital or nursing facility placement.

The individual's plan of care must demonstrate the need for PAC waiver case management services to coordinate access to all needed services regardless of the funding source. The case manager must document in the case notes efforts to access services through all available funding sources prior to utilizing PAC waiver services. The case manager must follow up on the delivery and quality of services provided to the recipient.

Plan of Care Components

A current written plan of care document must be maintained in the recipient's case record and include:

- The recipient's acuity level determination by the disease management organization nurse care manager and effective date;
- Identified problems and barriers to independent functioning in the home and community;
- Realistic goals and outcomes for resolving identified problems;
- All PAC waiver services to be provided to address identified problems, with a beginning date for each specific service;
- Services needed, including the providers' name and Medicaid ID number;
- The specific amount, frequency, duration, and estimated cost of PAC waiver services; and
- Documentation of the dates that services were revised or terminated.

Plan of Care, continued

Plan of Care Requirements

The plan of care must be signed and dated by the case manager and the recipient.

A copy of the plan of care must be given to the recipient and the care manager. Case notes must document that the recipient was given a copy of the plan of care.

The plan of care must contain all services to be received by the PAC recipient regardless of funding source, including case management services.

All services contained in a plan of care must be listed on the PAC Waiver Plan of Care Summary form.

Note: See Appendix F for a copy of the PAC Waiver Plan of Care Summary form.

Services Not Specified in the Plan of Care

Services not specified in the plan of care are not considered approved or authorized.

Medicaid reimbursement for services furnished, but not specified in the plan of care for that specific time period are subject to recoupment.

Note: See Chapter 5 of the Florida Medicaid Provider General Handbook, for additional information on Medicaid fraud and abuse.

Plan of Care Approval

The recipient and, if applicable, the recipient's family, guardian or designated representative and the case manager must meet to discuss and agree on the plan of care.

The plan of care must be signed and dated by the recipient (if applicable, the recipient's family, guardian or designated representative) and the case manager.

When the plan of care is signed, the case manager must provide the recipient with a choice of available providers for each PAC waiver service stated in the recipient's plan of care.

The case manager must also notify the recipient of the right to a fair hearing if services are denied, reduced or terminated and document this in the case notes.

The plan of care and the services in the plan are considered authorized when it is signed by the case manager.

Plans of care exceeding a cost of $1,000 per month must be approved through the exception request process before services are considered authorized.

Plan of Care, continued

Exception Requests (Appendix H)

A completed Request for Plan of Care Expenditure Exception form must be submitted to the DMO for approval when a service is needed that is not included under an acuity level, is in excess of the maximum limits or when the plan of care exceeds $1000 in any given month. The DMO will process all requests regarding needed waiver services. The request must include, at a minimum, the following information:

- Physician's prescription;
- Current level of care documentation (Notification of Level of Care, DOEA-CARES Form 607);
- Most current social needs assessment;
- Plan of care for the month in which the request is submitted;
- Itemized cost list and work orders for environmental accessibility adaptation or specialized medical equipment and supplies, if applicable;
- Narrative justification for the request; and
- Length of time for which the exception is requested.

The DMO will respond to the exception request within five working days of receipt.

Note: See Appendix H for the PAC Request for Plan of Care Expenditure Exception form. Providers may photocopy this form for their use.

Service Authorizations Transmitted within Five Working Days

In order to implement services authorized on a written plan of care, the case manager must transmit service authorizations on a Project AIDS Care (PAC) Waiver Service Authorization form to the specified providers, within five working days of signing the plan of care.

Note: See Appendix G for a copy of the Project AIDS Care (PAC) Waiver Service Authorization form.

Service Authorization Components

Case managers complete service authorizations for PAC waiver services on a Project AIDS Care (PAC) Waiver Service Authorization form. The service authorization must include the following:

- Claim authorization number;
- Provider name;
- Recipient's name, birth date, and Medicaid identification number;
- Recipient's address;
- Case management agency name and address;
- Name and telephone number of the case manager who authorized services on the plan of care;
- Special instructions;
- Service to be furnished with corresponding procedure code;
- Frequency and amount of service;
- Cost of service (maximum authorized expenditures); and
- Duration of services.

Plan of Care, continued

Plan of Care Reviews at least Every Six Months	The duration of services authorized may not exceed six months. The plan of care must be reviewed and updated at a face-to-face visit at least every six months, to reflect the current needs of the recipient. The case manager must monitor the plan of care for continuity of services and ensure that changes in the recipient's status warrant service increases, service reductions, or other changes in the plan of care. This review is not a complete reassessment. The case manager and the recipient must sign and date the plan of care at each review to certify that authorized services are appropriate and continue to be needed. Revisions to the plan of care must be documented in the case narrative.
Verifying Receipt of Services	Case managers must document in the case notes follow-up activities to ensure that service authorizations are implemented in accordance with the recipient's plan of care. Case managers must follow up with the recipient regarding the delivery and quality of all the services. Service providers must maintain documentation of valid service authorizations signed by the PAC waiver case manager, to provide the service and to submit a claim. Services that do not have valid authorizations from the case manager are subject to recoupment from the service provider.
Service Logs	Service providers must maintain documentation such as a service delivery log, of services provided to a recipient. The recipient must sign the log on the date service is delivered. In the event that a recipient is not available to sign the delivery log, a designated individual may be authorized to sign. Such arrangements must be made in advance with the case manager and only on a temporary basis for not more than one week.
Changes to Plan of Care and Amended Service Authorizations	When changes in the recipient's condition or acuity level warrant a change in the amount, frequency or duration of services, the case manager must update the plan of care to reflect the authorization of additional services. Copies of the updated plan of care must be given to the recipient and the care manager. The case manager must send amended service authorizations to the appropriate provider(s) within five working days of services being authorized in the recipient's written plan of care.

Plan of Care, continued

Social and Medical Needs Reassessed Annually at Minimum

The case manager and the care manager must perform a comprehensive needs reassessment (social and medical) on a PAC waiver recipient at least annually. If changes in the recipient's condition warrant a more frequent reassessment, one should be completed as needed and more frequently than once a year.

Results of the reassessment must be used to update the plan of care. The case manager must maintain the reassessments in the recipient's case record and note all contacts and visits made in the case narrative.

Covered Services

Introduction

PAC waiver services are based on individual recipient needs regardless of the funding source. At a minimum the recipient must demonstrate a need for PAC waiver case management services. All services must be documented on a plan of care.

Medicaid will reimburse only waiver services that are specifically identified in the approved plan of care by service type, frequency and duration, and that have a service authorization signed by the PAC waiver case manager for the dates of service.

Non-Duplication of Services

Services provided under the PAC waiver may not duplicate services that are provided under private insurance, other Medicaid services or other funding sources.

Covered Services

In addition to case management services, recipients may receive PAC waiver services based on the assessed acuity level or an approved exception request. Providers must maintain documentation of services provided to a recipient, such as a service delivery log signed by the recipient at the time of delivery.

Medicaid reimburses for the following PAC waiver services besides case management:

- Chore Services
- Chore Services – Pest Control
- Day Health
- Education and Support
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Homemaker
- Personal Care
- Restorative Massage
- Skilled Nursing – Registered Nurse (RN)
- Skilled Nursing – Licensed Practical Nurse (LPN)
- Specialized Medical Equipment and Supplies
- Specialized Personal Care for Foster Care Children
- Therapeutic Management of Substance Abuse

A description follows for each service that includes a service description, delivery requirements and service limitations.

Chore Services

Description

Chore services are needed to maintain the home in a clean, sanitary and safe environment. Chore services are not routine household maintenance tasks. The service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, or moving heavy items of furniture in order to provide safe access and egress.

Chore services will be provided only in cases where neither the individual or anyone else in the household is capable of performing or financially providing for them; and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of or responsible for their provision. The case manager must document in the case record that there are no other resources available to provide the service.

Lease agreements of rental properties must be examined to determine the responsibility of the landlord, prior to any authorization of services.

Delivery

Chore services may be provided only to recipients with limitations in activities of daily living and when there is no caregiver or any other support available.

Heavy Household Chores

Medicaid reimburses for heavy household chores to maintain a clean and sanitary living environment and reduce the potential for opportunistic infections for persons with AIDS. Such chores are not routine housekeeping activities, but include seasonal cleaning, washing floors, walls, windows and draperies, carpet cleaning, and heavy cleaning and sanitation of bathrooms and kitchens.

Household Maintenance

Medicaid does not reimburse for general household maintenance and upkeep such as changing light bulbs and air conditioning filters.

Removing Barriers to Safety and Access

Medicaid reimburses activities to remedy identified safety and accessibility barriers in the recipient's living environment. Services include:

- Moving heavy items or home furnishings to provide safe access and egress.
- Tacking down loose rugs and tiles, and external maintenance to steps and sidewalks.

Chore Services, continued

Service Requirements

Prior to the provision of services, the chore services provider must furnish:

- A detailed work order to the recipient and case manager outlining the scope of work and all supplies with associated costs required to complete the work;
- Notification of any potentially hazardous chemicals to be used; and
- The total cost of the service including labor.

Service Limitations

Chore services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Chore services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding source.

Chore Services – Pest Control

Description

Chore services – pest control is provided due to health and safety issues associated with pest infestation in a tropical climate. Pest control services are provided to eliminate insects, rodents and other potential carriers of disease that could be hazardous to persons with compromised immune systems if present in the recipient's living environment.

Service Requirement

Pest control services must be furnished by a licensed pest control business that is enrolled as a PAC waiver provider.

Prior to the provision of pest control services, the provider must furnish a detailed work order to the recipient and case manager outlining the scope of work, all supplies with associated costs required to complete the work, and notification of any potentially hazardous chemicals to be used.

Case Manager's Responsibilities

Prior to authorizing pest control services, case managers must:

- Ensure that no relative, caregiver, community or volunteer agency or third party is available to provide the services;
- Examine the lease agreement to determine the landlord's responsibility, if the recipient lives on rental property; and
- Check with the physician's office to see if pest control services may be harmful to the recipient's well being.

Service Limitations

Pest control services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Pest control services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding sources.

Day Health Care

Description

Day health care is an organized program of therapeutic social and health care activities, provided in an ambulatory setting, designed to restore or maintain the recipient's optimal capacity for self-care and health promotion.

Day health care services must be for four or more hours per day, which do not have to be a continuous time period, but must be on a regularly scheduled basis.

Day health care is required to provide at least one meal per day. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). The meals must be provided under supervision of a licensed dietitian or nutritionist.

Physical, occupational and speech therapies indicated in the individual's plan of care must be furnished as component parts of this service.

Transportation between the recipient's place of residence and the day health center must be provided as a component part of day health services.

Who Can Receive Services

These services are provided to recipients with functional limitations in activities of daily living or serious health conditions resulting from AIDS.

In order to be reimbursed for day health care services, the recipient must be present for a regularly scheduled minimum of four hours per day.

Service Requirements

A registered nurse (RN) or licensed practical nurse (LPN) must be on site during all hours of program operation.

Nutrition services must be provided under supervision of a licensed dietitian or nutritionist.

Dietitian Certification

Day health care providers must maintain documentation that a currently licensed dietitian or nutritionist has certified that meals provided meet the Recommended Dietary Allowances (RDA) requirements. The certification must include the dietitian's registration number and signature.

Day Health Care, continued

Required Services

To receive Medicaid reimbursement, the following services must be provided:

- Periodic nursing evaluations conducted at least monthly;
- Medication monitoring;
- Medical supervision of progress toward therapeutic goals identified in the recipient's plan of care;
- Dietary and nutritional education;
- At least one meal that meets one-third of the current daily Recommended Dietary Allowances (RDA) established by the Food and Nutrition Board of the National Academy of Sciences;
- Transportation between the recipient's residence and the day health center; and
- Therapeutic activities as described below.

Therapeutic Activities

Day health care must include the development and implementation of planned group or individual therapeutic activities provided in accordance with the goals identified in a recipient's plan of care for management of preventable disease and early intervention to promote optimal health.

Activities may include physical fitness, nutrition counseling, stress reduction techniques, and other specific measures to avoid declines in health status. They may also include health promotion programs to assist recipients in understanding how lifestyle impacts physical and mental health and to develop personal practices that enhance their total well being.

Activities of Daily Living

Day health care must also provide supportive care and supervision to recipients with functional limitations in activities of daily living resulting from AIDS or AIDS dementia. These recipients must be unable to care for themselves, because the individuals who normally provide care to the recipients are absent or need relief.

Service Limitations

Day health care services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Day health care services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding sources.

Education and Support Services

Description

Education and support services consist of face-to-face counseling and therapy services directed toward the elimination of psychosocial barriers resulting from the diagnosis of AIDS and progression of the disease.

Psychosocial counseling will be provided to waiver recipients, immediate caregivers and family members. This service is provided for treatment of the recipient's emotional and psychological condition, to maintain independent functioning, and to assist the recipient's direct caregivers in making a positive contribution to the recipient's ability to stay in the home and community setting.

Education and support services include the development of appropriate personal support networks, exploration of possible alternate behavior patterns, therapeutic social skills, identification of barriers to optimal interpersonal functioning, and development of a plan for counseling sessions to progress towards the resolution of the barrier.

Recipients that may benefit from psychiatric intervention or prescribed psychotropic medications, must be referred to a qualified community mental health provider.

Service Requirements

Education and support services must be based on an individualized support plan, which is a structured, goal-oriented schedule of services developed jointly by the recipient and the provider of education and support services.

The support plan must contain measurable objectives, anticipated outcomes, and planned interventions for resolution of barriers and the provision of AIDS-related education.

Service providers may not submit multiple claims for the same session or group therapy.

Support Plans and Quarterly Reports

The provider is required to submit to the case manager a copy of the recipient's education and support plan prior to its implementation. The provider is also required on a quarterly basis to send reports that outline milestones achieved by the recipient in the previous quarter. Reports should be submitted to the case manager within ten working days of the end of the quarter.

Education and Support Services, continued

Education and Support Services	Education and support services include: • Developing the recipient's personal support networks; • Assisting the recipient's caregivers in making positive contributions to the recipient's ability to remain in the home; • Identifying barriers to optimal interpersonal functioning; and • Developing or modifying the recipient's skills that are necessary to prevent institutional placement.
Non-Duplication of Services	Counseling, therapy and treatment services are provided under the Medicaid Community Behavioral Health Program. Education and support services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program.
Service Limitations	Education and support services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Environmental Accessibility Adaptations

Description

Environmental accessibility adaptations are those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the recipient, or which enable the recipient to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning and other similar items. Adaptations that add to the total square footage of the home are excluded from this benefit.

All services shall be provided in accordance with applicable state or local building codes.

The case manager must document the necessity for the service to prevent the institutionalization of the recipient.

Structural Modifications

Structural modification services include:

- Physical adaptations to the home that involve structural changes such as building ramps, widening doors and modifying bathroom facilities to accommodate wheelchairs and other assistive devices.
- Installation of specialized electrical or plumbing systems necessary to accommodate required medical equipment.

Structural modifications must be provided in accordance with a building permit when required and conform to applicable building codes. The structural modifications must be performed by a licensed contractor.

Water Filtration Systems

Medicaid reimburses the purchase and installation of a water filtration system where evidence of cryptosporidium is documented as being present in the recipient's local water supply. Water filtration systems must be able to filter basophilic spherules as small as absolute 1 micron.

Environmental Accessibility Adaptations, continued

Accessibility Adaptations	Medicaid reimburses the purchase and installation of grab-bars, specialized hardware and fixtures, and other devices required to compensate for a recipient's limitations in activities of daily living.
Service Requirements	Prior to the provision of service, the environmental accessibility adaptations provider must furnish a detailed work order to the recipient and case manager outlining the scope of work, all supplies with associated costs required to complete the work, the estimated time for completing the work, and the total cost of the service including labor.
Case Manager's Responsibilities	Prior to authorizing environmental accessibility adaptations services, case managers must: • Ensure that no relative, caregiver, community or volunteer agency or third party is available to provide the services; • Examine the lease agreement to determine the landlord's responsibility, if the recipient lives on rental property; • Ensure the recipient's safety if any potentially dangerous chemicals are to be used during service provision by documenting that the recipient's physician approves the service; • Document in the case record at least three itemized price quotations from providers; and • Submit an exception request when the total monthly service exceeds $1,000 per month or when environmental accessibility adaptations will exceed $250.
Service Limitations	Environmental accessibility adaptations services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager. The case manager must submit a Request for Plan of Care Expenditure Exception and a copy of the detailed work order for environmental accessibility adaptations that will exceed $250. Approval is needed before services are considered authorized. Environmental accessibility adaptation services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding sources. Note: See Appendix H for a copy of the PAC Request for Plan of Care Expenditure Exception.

Home Delivered Meals

Description

Home delivered meals service provides nutritionally sound meals, fresh or frozen, delivered directly to the recipient's home. Providers must meet all state regulatory requirements for preparation, packaging and delivery of home delivered meals and demonstrate compliance with program requirements.

Who Can Receive Services

Home delivered meals may be provided only when the following requirements are met:

- The recipient is not capable of preparing meals, is homebound and unable to shop for food to prepare meals. Recipients are considered homebound if they are unable to leave their residence without assistance or because it is medically contraindicated.
- No other person in the recipient's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation.
- The recipient has a physician's prescription for a therapeutic diet that can only be implemented through home delivered meals.

Service Requirements

The home delivered meals provider must demonstrate compliance with the following requirements:

- Maintain a formal sanitation program that complies with Chapter 10D-13, F.A.C. for sanitation and food safety and display a current certificate from the Department of Health.
- A physician's prescription for a therapeutic diet that meets the recipient's special dietary needs.
- Each meal must be individually packed and meet one-third of the current daily Recommended Dietary Allowances (RDA) established by the Food and Nutrition Board of the National Academy of Sciences. A maximum of two meals per day may be provided in containers that maintain safe temperatures. The two meals do not constitute a full daily regimen of three meals per day as recommended by the RDA.
- Maintain a quality assurance written plan and document quality improvement measures.
- Maintain a service delivery log that documents the signature of the recipient or designated person to acknowledge receipt of the home delivered meals.
- The provider must not leave meals unattended and in conditions that are not safe for consumption.
- The case manager and the home delivered meals provider must verify and document that the recipient is able to store food safely in a refrigerator or freezer and has the ability to heat a frozen meal.

Home Delivered Meals, continued

Contract with a Dietitian or Nutritionist	The home delivered meals provider must maintain a current written contract with a licensed dietitian or nutritionist to certify that meals provided meet the RDA requirements. The certification must include the dietitian's registration number and signature. The provider must maintain documentation to show that the dietitian or nutritionist continues to review meals on a quarterly basis.
Sub-Contracting Responsibilities	A home delivered meals service provider and sub-contractors must meet all state regulatory requirements for preparation, packaging and delivery of home delivered meals and demonstrate compliance with program requirements in the PAC Waiver Services Coverage and Limitations Handbook.
Freshly Prepared Meals	Freshly prepared meals must be delivered daily to the recipient's home. If necessary, additional instructions for heating the meal must be included. All foods must be packaged and transported under conditions that will ensure temperature control during delivery and prevent contamination and spillage. Hot and cold foods must be packaged separately. The temperature of hot foods and cold foods must be maintained at temperatures appropriate to ensure food safety.
Frozen Meals	Frozen meals may be delivered for daily consumption or in bulk for not more than one week's consumption. A maximum of 14 frozen meals may be delivered for consumption in a week. Frozen meals must have a satisfactory storage life, contain a preparation date, and be clearly labeled with instructions for storage and reheating. Frozen meals must be delivered at temperatures appropriate for ensuring food safety. When frozen meals are delivered to a recipient, the case manager must document in the plan of care that the recipient has the means for heating a meal. The home delivered meals provider must determine that the recipient has the means to store and cook the meals safely and in accordance with the directions provided.
Service Limitations	Home delivered meals services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager. Home delivered meals services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding sources.

Homemaker Services

Description

Homemaker services are provided for the purpose of maintaining the recipient's home in a clean and sanitary environment, and to compensate for functional limitations in activities of daily living resulting from AIDS.

Services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent, or the recipient is unable to manage his home and care.

Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.

Who Can Receive Services

Homemaker services may be provided only when the recipient is not capable of accomplishing household activities, and no other person in the recipient's household is able to accomplish household activities, or when the individual who usually performs these services is temporarily absent or unable to manage these household activities.

Covered Services

Medicaid reimburses general household activities provided by a trained homemaker, including routine housekeeping such as cleaning, dusting, vacuuming, laundry, assistance with shopping and occasional escort services, which are incidental to the care furnished, or which are essential to the health and welfare of the recipient, rather than the recipient's family.

Meal planning and preparation may be provided as part of this service when it is not provided through any other service.

Escort services can be provided to accompany the recipient to and from service providers and as language interpretation services.

Service Limitations

Homemaker services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Homemaker services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding sources.

Personal Care Services

Description

Personal care services provide assistance to a recipient with limitations in functioning related to eating, bathing, dressing, ambulating, using the toilet, and other activities of daily living. Personal care is not medical care, but may be hands-on assistance in areas of self care to maintain and improve the recipient's personal hygiene and health.

Covered Services

Medicaid reimbursement for personal care includes:

- Assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves.
- Personal care providers must meet state standards for this service as described in the Florida Medicaid Home Health Services Coverage and Limitations Handbook.

Service Requirements

Personal care services must be provided under a written program for the recipient that is developed by health care professionals including the attending physician.

Personal care services must be documented on a plan of care that complies with the care plan requirements in the Florida Medicaid Home Health Services Coverage and Limitations Handbook.

A registered nurse in accordance with the recipient's home health plan of care must supervise personal care services.

Non-Duplication of Services

Personal care services are provided under the Medicaid Home Health Program for recipients under age 21. Personal care services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program.

Note: The Florida Medicaid Home Health Handbook is available on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support.

Service Limitations

Personal care services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Personal care services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding sources.

Restorative Massage

Description	Restorative massage services are limited to recipients with peripheral neuropathy or severe neuromuscular pain and lymphedema.
Covered Services	This service includes evaluation and treatment. Included are an examination of six physiological factors which create or intensify pain in the body: ischemia, trigger points, nerve entrapment or compression, postural distortion, nutritional and emotional well being. The purpose of this service is to enhance the function of the joints, muscles and biomechanics (movement). The amount, duration and scope of this service will be managed to assure that the minimum medically necessary service is provided. Restorative massage services include an evaluation to determine the recipient's level of functioning and competencies through therapeutic observation and testing. Restorative massage treatment involves face-to-face encounters with a recipient for the purpose of providing massage therapy services.
Prescription Requirement	A licensed physician, advanced registered nurse practitioner, or physician assistant must prescribe restorative massage services.
Service Limitations	Restorative massage services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager. Restorative massage services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program or other funding sources.

Skilled Nursing – RN/LPN

Description	Skilled nursing services are provided to recipients who require medically-necessary skilled nursing care provided in their places of residence to maximize the health of the recipient. Medicaid reimburses skilled nursing services provided by registered nurses (RNs) and licensed practical nurses (LPNs) licensed to practice in the state of Florida. Examples of skilled nursing care includes infusion therapy; administration of intravenous medications; administration of intramuscular or subcutaneous injections and hypodermoclysis; replacement and sterile irrigation of catheters; colostomy and ileostomy care; treatment of decubitus ulcers; treatment of widespread infected or draining skin disorders; administration of prescribed heat treatments; restorative nursing procedures; nasopharyngeal or tracheotomy aspiration; ventilator care; and lavine tube and gastrostomy feedings.
Skilled Nursing by an RN	RN services include skilled nursing care rendered by an RN within the scope of Chapter 464, F.S. RN services may be intermittent or continuous nursing care.
Skilled Nursing by an LPN	LPN services include skilled nursing care rendered by an LPN within the scope of Chapter 464, F.S. LPN services may be intermittent or continuous nursing care.
Service Requirements	Skilled nursing must be ordered by a licensed physician prior to the provision of care. Skilled nursing services must be consistent with the written physician approved plan of care and comply with the requirements of the Florida Medicaid Home Health Services Coverage and Limitations Handbook. Skilled nursing services must also be consistent with accepted standards of medical and nursing practice. Note: The Florida Medicaid Home Health Handbook is available on the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support.
Non-Duplication of Services	Skilled nursing services and home health care are provided under the Medicaid Home Health Services Program. Skilled nursing services provided under the PAC waiver may not duplicate services that are provided under another Medicaid program.
Service Limitations	Skilled nursing services are limited to the amount, duration and scope of services described in the recipient's PAC waiver plan of care as authorized by the case manager.

Specialized Medical Equipment and Supplies

Description

Specialized medical equipment and supplies services include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

The service may include durable medical and adaptive equipment and consumable medical supplies, which are needed to promote, maintain and optimize health, to minimize the effect of illness and disability resulting from AIDS, or to compensate for limitations in activities of daily living.

Services needed for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment that are not available under another Medicaid program may be provided.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under another Medicaid program and shall exclude items that are not of direct medical or remedial benefit to the recipient. All items must meet applicable standards of manufacture, design and installation.

Plan of Care and Prescription Requirements

To be reimbursed by Medicaid, the medical equipment or medical supplies must be:

- Specifically identified in the recipient's plan of care; and
- Prescribed by a licensed physician, advanced registered nurse practitioner, or physician assistant.

Case notes must document comparative prices from three available providers.

Medical and Adaptive Equipment

Medical and adaptive equipment is medically-necessary equipment that can withstand repeated use, is appropriate for use in the recipient's home, and serves a medical purpose or enables the recipient to compensate for limitations in the ability to perform activities of daily living.

Medicaid reimbursement for medical and adaptive equipment services includes the purchase, delivery, set-up and installation in the home, and training and instruction to the recipient or caregiver.

Medical and adaptive equipment service may include maintenance and repair when performed by an authorized technician and no other source is available to provide the maintenance or repair.

Specialized Medical Equipment and Supplies, continued

Medical and Adaptive Equipment Service Requirements

Providers of medical and adaptive equipment and supplies must provide the recipient's caregiver with all the manufacturer's instructions, service manuals and operating guides needed for routine service and operation.

Providers or manufacturers of medical and adaptive equipment and supplies must guarantee the products for a minimum of one year. No replacement or repairs will be reimbursed for equipment within the first year of service.

Medical and Adaptive Equipment Report Requirements

Providers of medical and adaptive equipment must furnish a report to the recipient and case manager on the equipment furnished to the recipient that includes the following information:

- Full description of the item;
- Manufacturer's name and address;
- Model and serial number;
- List of parts, components, attachments and special features;
- Recipient's functional limitations warranting the equipment;
- Medical justification for all unique features and construction;
- Whether the service was the acquisition or the repair of the equipment; and
- Cost of equipment acquisition or repair.

Medical Supplies

Consumable medical supplies are medically-necessary medical or surgical items that are consumable, expendable, disposable or non-durable, and appropriate for use in the recipient's home. Medicaid only reimburses consumable medical supplies that if not provided could reasonably cause the recipient to require emergency treatment, become hospitalized, or be placed in a long-term care facility.

Consumable medical supplies must not exceed one month's supply.

Non-Duplication of Services

Durable medical equipment and supplies are provided under the Medicaid Durable Medical Equipment and Medical Supply Services Program. Specialized medical equipment and supplies provided under the PAC waiver may not duplicate services that are provided under another Medicaid program.

Specialized Medical Equipment and Supplies, continued

Service Limitations

Specialized medical equipment and supplies are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Specialized medical equipment and supplies that will exceed $250 must be approved through the exception request process. A copy of the physician's prescription and an itemized report of the medical equipment or supplies must be submitted.

Note: See Exception Request under Plan of Care in this chapter for additional information.

Note: See Appendix H of this chapter for a copy of PAC Request for Plan of Care Expenditure Exception form. Providers may photocopy this form for their use.

Specialized Personal Care Services for Foster Care Children

Description

Specialized personal care services for foster care children consists of a range of homemaking and personal care services furnished to foster children who have been diagnosed with AIDS. These are intense services that go well beyond those normally provided to well children in foster care.

Medicaid pays a daily rate to foster care providers for children with a diagnosis of AIDS. This rate is intended to cover the intense personal care provided to a foster child each day the child remains in care.

This payment will not include the provision of room and board, which is covered in the foster care board rate paid by the Department of Children and Families. Providers of this service must be licensed foster, group or shelter care homes.

Non-Duplication of Services

The PAC waiver will not reimburse for medical foster care services and personal care provided under the Medicaid Medical Foster Care Program and Medicaid Home Health Services Program for recipients under age 21.

Service Limitations

Foster children who receive specialized personal care services for foster care children are not eligible to receive personal care, homemaker, and companion services.

Therapeutic Management of Substance Abuse

Description	Therapeutic management of substance abuse includes evaluation and treatment of chemical dependency or substance abuse by an approved provider. This service is intended as a structured, goal-oriented service that is intended to improve or stabilize the recipient's condition to the point that services greater than occasional maintenance visits are no longer needed. Treatment is focused on reducing known risk factors associated with onset or progression of chemical dependency and other alcohol or drug related problems. Therapeutic management of substance abuse services may include, but are not limited to, early identification and screening, short-term counseling and treatment. It may include outpatient methadone maintenance. This service is intended to help waiver recipients maintain better general health thus decreasing the need for hospitalization or institutionalization.
Non-Duplication of Services	Evaluation and treatment of substance abuse are provided under the Florida Medicaid Community Mental Health Program. Therapeutic management of substance abuse provided under the PAC waiver may not duplicate services provided under another Medicaid program.
Service Limitations	Therapeutic management of substance abuse services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager.

Documentation for Covered Services

Service Documentation

Services must be rendered by qualified waiver providers pursuant to a written plan of care and a current service authorization, signed by the recipient's PAC waiver case manager. Unauthorized services will be in violation of the requirements and may result in recoupment or termination from the waiver.

Providers must maintain service delivery records such as a log for each date service is rendered to a PAC recipient.

The documentation must clearly describe the activities associated with maintaining the recipient in a community setting.

Note: See Chapter 2 of the Florida Medicaid Provider General Handbook for additional information about documentation requirements.

Required Documentation Elements

The case manager must maintain documentation of the following in the recipient's case record for all PAC waiver services or service components rendered to waiver recipients:

- Name of provider and provider agency rendering each service;
- Type of service provided;
- Amount of service provided;
- Date of service; and
- Place of service.

Permanent Record Documentation

All documentation must be in ink and must be legible. No erasures or correction fluid (white out) are permitted. Entries must be signed and dated. In case of an error, the provider must line through the error, initial and date it, and then make the correct entry.

Case Transfers and Termination of Services

Case Management Agency Transfers

PAC waiver recipients may elect to terminate case management services provided by one case management agency and transfer to another available case management provider.

Before transferring to another case management agency, the case manager must inform the recipient of all PAC waiver case management providers located in the area and provide the recipient with a choice of a new case management agency.

Transfer Request Form (Appendix J)

To complete the transfer, the recipient must sign and date a Project AIDS Care (PAC) Waiver Request to Transfer to Another PAC Waiver Case Management Agency. The current case management agency must send this request via registered mail, along with a complete copy of the recipient's case record, to the new case management provider within ten working days of the signed request.

Note: See Appendix J of this chapter for the Project AIDS Care (PAC) Waiver Request to Transfer to Another PAC Waiver Case Management Agency form.

Effective Date of Transfer

Case management services from the transferring case management provider will be terminated on the date the transfer request and case record are received by the new case management agency.

Termination of Services

PAC waiver services must be terminated or suspended for the following reasons:

- The recipient chooses not to receive a specific PAC waiver service;
- A specific PAC waiver service is no longer appropriate or needed;
- The recipient temporarily moves out of state or service catchment area; or
- The recipient is temporarily institutionalized or incarcerated for more than 30 days.

Temporary suspension of waiver services does not terminate a recipient's participation in the PAC waiver.

Case managers must provide PAC waiver recipients with at least ten days advance notice of any termination or suspension that is initiated by the case management provider.

Case Transfers and Termination of Services, continued

Termination of Participation

A recipient's participation in the PAC waiver must be terminated when the recipient:

- Chooses to stop participating in the PAC waiver;
- Becomes ineligible for Medicaid;
- No longer meets the PAC waiver eligibility criteria;
- Elects to reside in a nursing facility;
- Is incarcerated;
- Is admitted to a residential treatment program;
- Is unable from a health stand point to be safely maintained in the home;
- Enrolls in another Medicaid waiver program;
- Elects to receive services from a Medicare or Medicaid HMO;
- Elects to enroll in a Medicare or Medicaid hospice; or
- Expires.

Case Manager's Responsibilities

When a recipient's participation in the PAC waiver is terminated, the case manager must immediately:

- Notify all service providers to cancel PAC waiver services that are being provided to the recipient; and
- Notify the local DCF office of the termination.

Advance Notice

Case managers must provide PAC waiver recipients with at least ten days advance notice of any termination or suspension initiated by the case management provider.

Right to a Fair Hearing

Right to a Fair Hearing

A recipient has the right to appeal any action taken by AHCA, DOEA, DCF, case management agencies or service providers that adversely affects the receipt of services.

Any advance notice of termination in services or program participation given to the PAC recipient must also provide information regarding rights to a fair hearing.

CHAPTER 3
PROJECT AIDS CARE WAIVER SERVICES PROCEDURE CODES AND FEES

Overview

Introduction

This chapter provides and describes the procedure codes, maximum units of service and approved fees for the Project AIDS Care (PAC) waiver services.

In This Chapter

This chapter contains:

Reimbursement Information

Provider Responsibilities

The provider may not bill for a service until the service is rendered and the provider has satisfied the service log documentation requirements. The provider is responsible for verifying the recipient's eligibility prior to rendering the service. Services are limited by the recipient's acuity level.

Note: See Appendix I for the Acuity Levels.

Non-Institutional 081 Claim Form

PAC waiver services are billed on the Non-Institutional 081 claim form.

Note: See the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, for specific procedures for submitting claims for payment.

Reimbursement Information, continued

Services and the Hierarchy of Reimbursement

Case managers must coordinate access to services through all available funding sources prior to accessing PAC waiver services. Services cannot be provided under the PAC waiver if they are available from another funding source. Other funding sources must be accessed in this order:

1. Third Party Payer
2. Medicare
3. Other Medicaid programs
4. PAC waiver

No service may be provided under the PAC waiver if it is already provided by another Medicaid program unless the nature or the amount of service when provided under the waiver would not be covered if provided under the other Medicaid program.

If a PAC recipient is dually-eligible under Medicare and Medicaid, the case manager must authorize those providers that are enrolled as Medicare and Medicaid providers so that any services that are covered by Medicare can be billed to Medicare first before billing to Medicaid. For example, Medicaid cannot reimburse a non-Medicare home health agency for Medicare reimbursable services rendered to a dual-eligible recipient.

Other Medicaid program services must be accessed when possible prior to utilizing PAC waiver services. For example, the Medicaid Durable Medical Equipment and Medical Supplies Program services must be accessed before utilizing PAC waiver specialized medical equipment and supplies.

Case managers may authorize PAC waiver services when the service is not provided by or the benefit has been exhausted through another funding source such as private insurance, Medicare, or other Medicaid programs.

Reimbursement Information, continued

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes, Level 1 and Level 2. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyright 2003 by the American Medical Association. All rights reserved.

Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code.

Level 2 procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits.

Effective October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

For dates of service prior to October 16, 2003, the provider must use procedure codes that were payable at that time.

Note: See Appendix A, Procedure Codes, Reimbursement and Maximum Limits for the procedures codes that were in effect for dates of service prior to October 16, 2003, and for the codes in effect for the dates of service on and after October 16, 2003.

Appendix A: Procedure Codes, Reimbursement and Maximum Limits

Each procedure code listed on Appendix A, Procedure Codes, Reimbursement and Maximum Limits corresponds to a service described in Chapter 2 of this handbook.

The Procedure Codes, Reimbursement, and Maximum Limits table lists:

- Name of the service;
- Codes associated with the service;
- The maximum fee that Medicaid will reimburse for the procedure; and
- The maximum number of reimbursable units.

Maximum Fees

Medicaid reimburses PAC waiver services at the maximum fee or the provider's usual and customary fee, whichever is lower.

Reimbursement Information, continued

Units of Service

Unless otherwise noted PAC waiver services are reimbursed in time increments. Each time increment is called a unit of service. Fifteen minutes equals one unit of service in most cases.

To receive reimbursement, PAC providers must total units of service provided to a PAC waiver recipient for each date of service, and submit one claim for the appropriate number of units of service for each date of service.

Case Management

To receive the monthly flat fee reimbursement for case management, the PAC waiver case management agency must submit one claim form for the last day of the month as the whole date of service.

Exceptions to submitting case management claims on the last day of the month are:

- When a recipient is admitted into a hospital or nursing facility, the claim must be for the day prior to the date of admission; or
- When a recipient expires, the claim must be for the day prior to the date of death.

Case management services and follow up activities to authorized services must continue to be documented in the case notes.

The case manager's travel time and time spent recording progress notes are integral components of case management, not separately reimbursable activities.

Procedure Code Modifiers

Definition of Modifier

For certain types of services, a two two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

The modifiers are entered in the field next to the procedure code field in item 33, under Modifier.

PAC waiver services providers must use the modifiers with the procedure codes listed on Appendix A, Procedure Codes, Reimbursement and Maximum Limits, when billing for the specific services in the procedure code descriptions. The modifiers listed in Appendix A can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: See in the Florida Medicaid Provider Reimbursement Handbook, No-Institutional 081, for additional information on entering modifiers on the claim form

APPENDIX A
PAC WAIVER SERVICES PROCEDURE CODES, REIMBURSEMENT AND MAXIMUM LIMITS

Non-Duplication of Services: PAC waiver services may not duplicate services available through other funding sources or other Medicaid programs.

Exception Requests: An exception request may be submitted when a service is needed and is not indicated under an acuity level, or is needed in excess of the maximum limits.

SERVICE	PROCEDURE CODE	MODIFIER	REIMBURSEMENT PER UNIT	MAXIMUM LIMIT
Case Management	G9012	U8	$100 per month	1 Unit ($100) per consumer per month
Chore – Other	S5120	U8	$25 per job	Not to exceed $150 per year
Chore – Pest Control	G9005*	U8	$25 per job	Not to exceed $150 per year
Day Health Care	S5100	U8	$2.50 per 15-minute unit	40 units (10 hours) per day
Education and Support	96152	U8	$10 per 15-minute unit	8 units (2 hours) per month
Environmental Accessibility Adaptations	S5165	U8	$250 per unit	8 units or $2000 per year whichever is lower
Home Delivered Meals	S5170	U8	$5 per Home Delivered Meal unit	62 meals per month or two meals per day
Homemaker	S5130	U8	$2.50 per 15-minute unit	32 units (8 hours) per day
Personal Care	99509	U8	$2.75 per 15-minute unit	16 units (4 hours) per day
Skilled Nursing - LPN	T1003	U8	$7 per 15-minute unit	32 units (8 hours) per day
Skilled Nursing - RN	T1002	U8	$10 per 15-minute unit	32 units (8 hours) per day
Restorative Massage	97124	U8	$8.75 per 15-minute unit	8 units (2 hours) per month
Specialized Medical Equipment and Supplies	E1399	U8	$250 per purchase	$250 per purchase per month
Specialized Personal Care for Foster Children	S5145	U8	$37 per day	$37 per day
Therapeutic Management of Substance Abuse	T1007	U8	$8.75 per 15-minute unit	16 units (4 hours) per day

*Effective for dates of service beginning January 1, 2005

APPENDIX B

PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION

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PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION

1. APPLICANT

Name: _____

Date of Birth: _____/_____/_____ Medicaid ID#: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Age: _____ Sex: _____ Race: _____ Languages spoken: _____

Annual Income: $_____ Assets: $_____

Name of designated representative: _____ Phone: (_____)_____

2. THIRD PARTY PAYOR INFORMATION

Applicant receives Medicare? ____YES ____NO

Medicare #:_____ _____ Effective Date: Part A: _____ Part B: _____

Applicant has Other/Private Insurance? ____YES ____NO

Name of Insurance Company: _____

Policy #:_____ Date _____ Phone Number: _____

Address: _____

Applicant currently enrolled with a HMO? ____YES ____NO

If YES complete the following: Name of HMO(s)_____

Commercial HMO? ___YES ___NO Medicare HMO? ___YES ___NO

Additional information such as policy number, phone number and comments:

3. ELIGIBILITY

Medical diagnosis of AIDS? ___YES ____NO

(If NO the applicant is not eligible for enrollment in the PAC Waiver. Refer applicant to other funding sources such as Ryan White services.)

PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION

Medicaid eligible? ___YES ____NO If YES, specify the Medicaid program:

SSI Effective Date: _____

MEDS-AD Effective Date: _____

Cash Assistance (was AFDC) Effective Date: _____

Other (specify) Effective Date: _____

Medically Needy The applicant is not eligible for enrollment in the PAC Waiver. Refer applicant to other funding sources such as Ryan White.

If NO, applicant is NOT eligible for enrollment in the PAC Waiver. Refer applicant to apply for Medicaid at Social Security Administration for SSI or the Department of Children and Families, or refer to other funding sources such as Ryan White services.

Enrolled in a Medicaid HMO? ___YES* ____NO

Elected Hospice services? ___YES* ____NO

*If the answer is YES for either, the applicant is NOT eligible for enrollment in the PAC Waiver.

Applied for Social Security Disability (SSDI) benefits? ___YES ___NO Date of application: _____

If Approved: Effective Date of SSDI Award: _____

If Denied: Effective Date of SSDI Denial: _____

Has decision been appealed? ____YES ____NO Date of appeal: _____

Applicant has never applied and plans to apply for SSDI on (Date) _____

Comments:

4. LEVEL OF CARE (LOC) DETERMINATION BY DOEA/CARES FOR RISK OF HOSPITALIZATION OR PLACEMENT IN A NURSING FACILITY:

Evaluation completed on: _____ Effective Date of LOC: _____

Applicant chooses to receive services in the home? ___YES ____NO

Can applicant be served safely in the home: ___YES ____NO

Comments:

PRIMARY CARE PROVIDER

Currently under the care of a primary medical care provider? ___YES ____NO

Primary Care Provider's Name: _____ Phone #_____

Address:

List other current medical care providers.

Name: _____ Phone #_____Address:_____

Name: _____ Phone #_____Address:_____

Name: _____ Phone #_____Address:_____

Name: _____ Phone #_____Address:_____

5. SUPPORT SYSTEMS

Source of referral to PAC Waiver program: _____

The applicant receives assistance with daily activities: ___YES ____NO

If Yes: Name of helper:_____ Phone #: _____

The applicant has legal representation: ___YES ____NO

If Yes: Name:_____ Phone #: _____

Household is aware that the applicant has been diagnosed with AIDS? ___YES ____NO

Person to be notified in case of an emergency: Name:_____

Relationship: _____ Phone: _____

Persons designated by the applicant to participate in the planning and provision of care:

Name:_____ Relationship: _____Phone #: _____

Name:_____ Relationship: _____Phone #: _____

Agencies or entities currently providing services:

Service:_____Provider: _____

Phone _____Address:_____

Service:_____Provider: _____

Phone _____Address:_____

PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION

PARTICIPANT RIGHTS AND RESPONSIBILITIES

Rights and Responsibilities of participants in the Project AIDS Care waiver program:

I. FREEDOM OF CHOICE

- You choose enrollment in the PAC waiver program instead of placement in a nursing home or hospital.
- You choose to receive services in your home.
- You have the right to choose any qualified, available, service provider to receive PAC waiver services.
- You have the right to choose any enrolled case management agency to receive case management services from a case manager, to the extent available.
- You have the right to receive waiver services you need; these may or may not include all the services you desire.

II. RIGHT OF APPEAL AND REQUEST FOR A FAIR HEARING

- You have the right to appeal a decision that denies you a service you believe you are eligible to receive.
- You have the right to request a fair hearing if services are reduced, terminated or denied. Your case manager can assist you in requesting a hearing from the local office of Economic Self Sufficiency, Department of Children and Families or the Office of Appeal Hearings, Department of Children and Families.

III. RESPONSIBILITIES

- You are responsible for assisting your case manager in developing your Plan of Care and scheduling services.
- You are responsible for keeping scheduled appointments and accepting offered and necessary services.
- You are responsible for demonstrating behavior that is cooperative, assertive, and respectful of others.
- You are responsible for notifying your case manager when you will not be available to receive services or sign a delivery log acknowledging receipt of services.
- You are responsible for notifying your case manager of the name, phone number and address of a person you have designated for a period not longer than one week, to sign a delivery log on your behalf.
- You are responsible for notifying your case manager when you are dissatisfied with the services you receive.
- You are responsible for following health care instructions to the best of your ability.
- You are responsible for maintaining required contact with your case manager and cooperating with other requirements of the program

_____ _____

Signature of the Applicant ***Date***

PROJECT AIDS CARE WAIVER ENROLLMENT APPLICATION

PARTICIPANT ENROLLMENT

☐ I am applying for enrollment in the Project AIDS Care (PAC) waiver program. I understand that there are multiple components in the application process, which I agree to complete to the best of my ability. I understand my PAC waiver case manager will notify me when I am fully enrolled.

☐ I authorize the PAC waiver case manager to obtain information needed to determine my eligibility to enroll in PAC waiver and to develop a personalized Plan of Care.

☐ I authorize the disease management organization nurse care manager to obtain information needed to complete an annual medical assessment and determine an acuity level to receive PAC waiver services.

☐ My rights and responsibilities have been explained to me.

☐ I choose to enroll in Project AIDS Care waiver if I am eligible.

☐ I choose to receive my case management services from:

Name of Case Management Agency: _____

Agency Address: _____

_____ Agency Phone Number: _____

Signature of Applicant: _____ Date: _____

Print name of applicant: _____ **Slot Number:** _____

***Signature of Witness*:** _____ Date: _____

Print name of witness: _____

***Signature of Case Manager*:** _____ Date: _____

Print name of case manager: _____

Name of Public Assistance Worker: _____ Date Notified: _____

_____

CASE MANAGER'S NOTES:

PROJECT AIDS CARE WAIVER AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION TO
THE MEDICAID CONTRACTED DISEASE MANAGEMENT ORGANIZATION

I, _____ authorize my Project AIDS Care (PAC) Waiver case management agency _____ to release information to the Registered Nurse Care Manager, from the Medicaid contracted disease management organization _____ for the completion of a medical needs assessment at home and an acuity level determination, required by PAC Waiver to receive services.

This authorization will remain in effect until I request in writing at any future date, that it be withdrawn.

I am aware that by refusing to have a medical needs assessment completed by the Registered Nurse Care Manager from the disease management organization, I will not be eligible to receive PAC Waiver services.

Print Name of Case Manager: _____

PAC Waiver Medicaid Provider #:_____

Date: _____ PAC Case Manager's Signature: _____

Print Name of Recipient: _____ **Medicaid ID#**_____

Date of Consent: _____ **Date of Refusal:** _____

Recipient's Signature:_____

APPENDIX C

PAC PHYSICIAN REFERRAL AND REQUEST FOR LEVEL OF CARE DETERMINATION (CARES FORM 607)

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PROJECT AIDS CARE
PHYSICIAN REFERRAL and REQUEST for LEVEL OF CARE DETERMINATION

(Clients Diverted from Hospitals)

Incomplete forms will be returned. Please complete all items. If non-applicable please indicate with N/A. Attach extra sheets or supporting documentation if necessary.

Client's Name:_____SSN#_____DOB_____

1. AIDS Diagnosis (initial, if yes)_____ (Please indicate Opportunistic infections on reverse side of form)

2. CD4 count _____% _____ Viral Load _____as of_____(Date)
(Percentage) (Absolute)

Defining AIDS without opportunistic infection:..... CD4 Absolute count of less than 200 OR

CD4 Percentage of less than 14

3. Medications (please list all prescribed medications): .

4. All body systems have been reviewed and specific physical findings are checked below.

___	Vision and Hearing	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Respiratory	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Gastrointestinal	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Genito-Urinary	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Cardiovascular	☐ Normal	☐ Moderate Impairment	☐ serious Impairment
___	Musculoskeletal	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment
___	Neurological	☐ Normal	☐ Moderate Impairment	☐ Serious Impairment

5. Medical History Significant to Home Based Care: _____

_____

_____

_____

6. Treatment & therapies: Please check all that apply.

___ Physical Therapy ___ Occupational Therapy ___ Respiratory Therapy
___ Substance Abuse Treatment ___ Massage Therapy ___ Other _____

7. Diet:_____

8. Prognosis: ___ Good ___ Poor ___ Fair Rehabilitation Potential: ___ Good ___ Poor ___ Fair

.

9. Unmet Home based care needs: _____

_____

_____

OPPORTUNISTIC INFECTIONS

BACTERIAL INFECTIONS

___ Mycobacterial infections
___ Nocardiosis
___ Salmonella Bacteremia
___.Syphillis or Neurosyphilis
___ Multiple Bacterial Infections

FUNGAL INFECTIONS

___ Aspergillosis
___ Candidiasis
___ Coccidioidomycosis
___ Cryptococcosis
___ Histoplasmosis
___ Mucormycosis'

VIRAL INFECTIONS

___ Cytomegalovirus Disease
___ Herpes Simplex-Mucocutaneous
___ Herpes Zoster
___ Progressive Multifocal Leukoencephalopathy
___ Hepatitis

PROTOZOAN OR HELMINTHIC INFECTIONS

___ Cryptosporidiosis
___ Isosporiasis
___ Microspondiosis
___ Pneumicystis Carinii
___ Pneumonia
___ Extrapulmonary Carinii
___ Infection
___ Stongyloidiasis, Extra-Intestinal
___ Toxoplasmosis

MALIGNENT NEOPLASMS

___ Cervical Cancer, Stage II+
___ Kaposi's Sarcoma with Wide-spread Involvement
___ Lymphoma
___ Squamous Cell Carcinoma of the Anus

HEMATOLOGIC DISORDERS

___ Anemia
___ Granulocytopenia
___ Thrombocytopenia

OTHER COMPLICATIONS

___ HIV Wasting Syndrome
___ Chronic Diarrhea
___ Chronic Weakness
___ Cardiomyopathy
___ Nephropathy
___ Sepsis
___ Meningitis
___Pneumonia
___ Endocarditis
___ Septic Arthritis
___ Peripheral Neuropathy
___ HIV Encephalopathy/ Dementia

10. Other: Repeated manifestations of HIV infection resulting in significant, documented symptoms of one or more of the following:

___ Restrictions in activities of daily living (Check all that apply):

Ambulation___ Transfer Skills___ Eating Skills___ Dressing Skills___ Personal Hygiene Skills___

Specify other ADL restrictions: _____

_____

___ Restrictions in Maintaining Social Functioning (Inability to interact appropriately and communicate effectively with others.

___ Difficulties in Completing and Maintaining Tasks in a Timely Manner Due to Deficiencies in Concentration, Persistence, or Pace (Cannot perform these activities due to fatigue or effects of medication on concentration and coordination.

Specify other mental or physical limitations: _____

_____

11. Do you believe the client is a danger to self and/or others? YES _____ NO _____

Comments: _____

12. Based on the patient's medical history and current condition, I certify that this individual is disabled and I believe there is reasonable indication that this individual might require hospitalization in the absence of home and community based services provided through a Medicaid waiver program.

Effective Date of Level of Care "At Risk of Hospitalization" _____

13. Physician signature: _____

Physician's name: _____ Date: _____

Address: _____ Telephone: _____

APPENDIX D

LEVEL OF NEED ASSESSMENT CASE MANAGEMENT TOOL (SOCIAL ASSESSMENT)

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Project AIDS Care Waiver: Level of Need (LON) Assessment
Case Management Tool

Instructions: Identify the initial Level of Need (LON) by entering a number on the criteria that best describes the client's situation. Use the space labeled (B) for the first re-assessment, and the spaces labeled (C) and (D) for any following re-assessments.

Client Name: _____ Client Case Number: _____
(Please print)

Life Area	Brief Intervention (0 points)	Minimal Intervention (1 point)	Moderate Intervention (2 points)	Intensive Intervention (3 points)
HIV Disease Progression Initial Score_____ (B)____ (C)____ (D) ____	No HIV symptoms	HIV symptoms present	HIV symptoms moderate	Severe medical condition and needs
Adherence to Medical Treatment Initial Score_____ (B)____ (C)____ (D) ____	Consistently keeps medical appointments	Currently receiving medical care occasionally missed appointments	Frequently missed appointments	Non-adherent to medical treatment and seeing severe disease manifestations
Medications Initial Score_____ (B)____ (C)____ (D) ____	Filling medication prescriptions; self-administering medications as prescribed; no medications prescribed	Taking medications with assistance; no medications desired; occasionally misses taking medications	Medication side effects; difficulty filling medications (i.e. transportation, money etc); not taking medications as prescribed; frequently misses taking medications	Loss of access to medications; pregnant client not taking medications; self-medication without medical direction; newly diagnosed; misses taking all medications

Project AIDS Care Waiver: Level of Need (LON) Assessment
Case Management Tool

Life Area	Brief Intervention (0 points)	Minimal Intervention (1 point)	Moderate Intervention (2 points)	Intensive Intervention (3 points)
Substance Abuse Initial Score_____ (B)____ (C)____ (D) ____	No substance abuse issues currently; history of substance abuse; clean for one or more years	Current substance usage; currently in substance abuse treatment; adherent to substance abuse treatment	Current problems with alcohol/drugs affecting self, family, friends, work, etc; continued use of substance despite consequences; on-going intervention required to support adherence to substance abuse treatment	Danger to self and/or others
Mental Health Initial Score_____ (B)____ (C)____ (D) ____	No current mental health issues identified; past mental health issues	Adherent to mental health treatment; taking psychotropic medications as prescribed; some counseling needed	Needs ongoing counseling; needs assistance with adherence to mental health treatment (i.e., psychiatric care, counseling, medications)	New HIV diagnosis; danger to self and/or others; needs immediate attention to mental health crisis
Other Medical Need Initial Score_____ (B)____ (C)____ (D) ____	No referral needed; healthy; no assistance needed to access eye, dental, nutrition, and other medically related needs	Referral needed; requires minimal assistance with access to preventative services or other medically related services	Priority referral; requires moderate intervention with barriers to access preventive or medical services	Urgent referral; requires intensive immediate intervention with preventive or other medical services

Project AIDS Care Waiver: Level of Need (LON) Assessment
Case Management Tool

Life Area	Brief Intervention (0 points)	Minimal Intervention (1 point)	Moderate Intervention (2 points)	Intensive Intervention (3 points)
Health Insurance/Benefits Initial Score_____ (B)____ (C)____ (D) ____	Insured; receives Private, Ryan White, Medicaid, Medicare medical services currently	Requires assistance with co-pay	Requires assistance to retain PAC or other health-related services and/or insurance programs, i.e., Ryan White, Medicare, etc.	Uninsured; not eligible for Ryan White, Medicaid, OR Medicare services; no income
Financial Assets/Needs Initial Score_____ (B)____ (C)____ (D) ____	Able to meet monthly financial obligations; steady income	Expenses greater than income	Eligible to receive financial assistance; requires supplemental financial services	No income; not eligible to receive financial assitance
Support System (family, significant other, spiritual, support group(s), professional caregiver, buddy/companion) Initial Score_____ (B)____ (C)____ (D) ____	Dependable, readily available support system(s) in place	Support system(s) not readily available; requires minimal assistance	Support system(s) not dependable; requires moderate assistance for self; requires assistance with dependent children	No support system available and requires immediate intervention
Language/Literacy Initial Score_____ (B)____ (C)____ (D) ____	Client can speak English; reads/writes English at or above 9th grade level; can complete documents in English	Primary language not English, but can speak English; reads/writes English at 6th to 8th grade level; reads/writes primary language at 9th grade and above	Client can speak English, but does not read or write English; reads/writes primary language at 6th to 8th grade level	Client cannot speak, read, write English; needs interpreter; cannot complete documents in English; reads/writes primary language at a 1st to 5th grade level

Project AIDS Care Waiver: Level of Need (LON) Assessment
Case Management Tool

Life Area	Brief Intervention (0 points)	Minimal Intervention (1 point)	Moderate Intervention (2 points)	Intensive Intervention (3 points)
Culture Initial Score_____ (B)____ (C)____ (D) ____	No cultural barrier to accessing, understanding services	Minimal culture barriers to accessing/understanding all service areas; accepts providers/services outside of their culture	Moderate barriers to accessing/understanding services; accepts some providers/services outside of their culture	Needs interpreter; accepts provider/services of their own culture
Housing Initial Score_____ (B)____ (C)____ (D) ____	Has permanent or stable housing	Requires assistance to retain housing	Homeless shelter; temporarily living with others; imminent homelessness; has transitional housing	Homeless; evicted; safety hazards present (i.e., substandard housing, domestic violence, hostile living environment)
Transportation Initial Score_____ (B)____ (C)____ (D) ____	Able to meet all transportation needs	Occasional transportation needs; bus pass needed	Needs help accessing transportation; unable to meet transportation needs by public transportation	Lacks transportation and unaware of transportation resources
Functional Assessment/ Activites of Daily Living (ADL)=bathing, toileting, dressing eating, ambulating/ transferring, cognitive awareness, food preparation Initial Score_____ (B)____ (C)____ (D) ____	No impairment in Activities of Daily Living (ADL)	Functional impairment corrected with adaptive equipment or assistance of caregiver or support person	Requires assistance from external agencies for ADL; functional impairment for one or more ADL	Requires assistance for three or more ADL; no caregiver/support; at risk for institutionalization
Legal Needs Initial Score_____ (B)____ (C)____ (D) ____	No legal issues; pre-need legal documents completed	Client requests assistance completing pre-need legal documents (living will, health care surrogate, etc.)	Legal issues (i.e., parole, community control, family reunification, alimony); permanence planning (legal guardianship for dependents)	Legal crisis (i.e., eviction, deportation, green card, child(ren) removal from home)

Project AIDS Care Waiver: Level of Need (LON) Assessment
Case Management Tool

Scoring:

The total score will be found in a range that will become the Level of Need for the client. The total score is calculated by adding the score from each life area for which the client was assessed. The two charts following will allow you to document the Level of Need for this client.

Score	Level of Need
0 points	Brief
1 to 15 points	Minimal
16 to 30 points	Moderate
31 to 45 points	Intensive

Project AIDS Care Waiver: Level of Need (LON) Assessment
Case Management Tool

Assessment	Date	Score	Level of Need (LON)	Completed by (print name and title)
Initial	___/___/___			
Revised (B)	___/___/___			
Revised (C)	___/___/___			
Revised (D)	___/___/___			
Revised (E)	___/___/___			

Write the word Brief, Minimal, Moderate in the LON column to describe the level of need based on scoring.

Schedule of Client Follow-up

Level of Need	Score	Contact at Least By Phone	Contact at Least Face to Face
Brief	0 points	Every 6 months	Every 12 months
Minimal	1 to 15 points	Every 2 months	Every 6 months
Moderate	16 to 30 points	Every month	Every 3 months
Intensive	31 to 45 points	Every 2 weeks	Every month

Follow-up to be continued until client moves to a lower Level of Need.

APPENDIX E

LEVEL OF NEED (MEDICAL ASSESSMENT)
PHC INITIAL CARE MANAGEMENT ASSESSMENT

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DATE: _____ SEVERITY LEVEL _____

PHC Initial Care Management Assessment

Client Contact Information – Section A		
First Name:	Last Name	DOB:
SS#:	MediPass #:	Recipient ID#:
AHCA Address:		
City:	Zip:	County:
Primary Address:		
City:	Zip:	County
Mailing Address:		
City:	Zip:	
Home Phone:	Cell Phone:	Pager:
Work Phone:	FAX:	E-Mail:
AHCA Supplied Address Correct: □ YES □ NO	AHCA Correction Sent: □ YES □ NO	Date:

Alternative Contact/ Healthcare Consent Information – Section B	
Emergency Contact Person:	Relationship:
Address:	City/State/Zip
Aware of HIV Status: □ YES □ NO	Phone:
Advance Directive Information Supplied: □ YES □ NO	Comment:
Durable Power of Attorney for Healthcare: □ YES □ NO	Living Will: □ YES □ NO
Designated Person:	Relationship:
Address:	City/State/Zip
Aware of HIV Status: □ YES □ NO	Phone:
Physician has a copy: □ YES □ NO	

Client Demographic Information – Section C

✔	Marital Status	✔	Race	✔	Gender	✔	Housing
	Single		Caucasian		Male		Alone
	Married		African American		Female		With Spouse
	Widowed		Haitian		Transgender M>F		Spouse and Children
	Separated		Hispanic		Transgender F>M		Blood relative
	Divorced		Native American	✔	**Sexual Orientation**		Domestic Partner
	Domestic Partner		Pacific Islander		Heterosexual		Group Home
	Other:		Asian		Bisexual		Shelter
✔	**Dependents**		Other:		Gay		Homeless
	Children	✔	**Primary Language**		Lesbian		Skilled Nursing Facility
	Age:_____ Sex:_____		English	✔	**Risk Category**		Shared/Roommate
	Age:_____ Sex:_____		Spanish		Decline to state	✔	**Education**
	Age:_____ Sex:_____		Creole		Transfusion		None
	Age:_____ Sex:_____		French		Hemophiliac		K-6th
	Age:_____ Sex:_____		Other:		IVDU		7-12
	Mother	✔	**Written Materials**		MSM		Some College
	Father		English		MSM/IVDU		College Graduate
	Sibling		Primary Language		Sex Worker		Post Graduate
	Domestic Partner		Braille		Mother/Child Transmission	✔	**Income**
	Other		Non-Reader		Heterosexual		None
✔	**Support System**	✔	**Mailings**	✔	**Safer Sex**		<$10,000
	Family		All materials OK		Condoms Always		>$10K <$20K
	Friends		Thrive Only		Condoms Mostly		>$20K <$30K
	Church		Education/PHC		Condoms Sometimes		>$30K <$40K
	ASO:		No Mail		Condoms Never		Other

Social Demographics

EMPLOYMENT INFORMATION – Section D

Occupation:	Employed: ☐ YES ☐ NO ☐ CASH	
Employer:		Hours Worked per week:
Address		Phone
City	County	Zip
Health Benefits: ☐ YES ☐ NO	Commercial Health Plan:	
Disabled: ☐ YES ☐ NO	Date Disabled:	Applied for SSDI: ☐ YES ☐ NO

LIVING ENVIORNMENT – Section E

✔	Dwelling	✔	Dwelling	Number of persons in the household:		
	☐ Own ☐ Rent ☐ HOPWA ☐ Other			Question	Yes	No
	Single family dwelling		Rehab Center	Do other household members know HIV Status?		
	Condominium		ACLF	Who:		
	Apartment		Hotel	Other in home HIV Positive?		
	Room			Who:		
	Shelter			Caregiver available if necessary		
	Nursing Facility			Who:		

✔	Pets	Relationship:	Phone
	Dog #		
	Cat #		
	Bird #		
	Reptile #		
	Other &#		

✔	Utilities	✔	Appliance	✔	Transportation
	Running Water		Stove		Car
	Electricity		Refrigerator		Family/Friends
	Gas		Air Cond		Bus
	Phone		Microwave		Other
					Other
	VCR		DVD		Cassette Player
	CD Player				Computer

Who Cleans up:	
Home Communication Media: (Equipment for education materials)	

SOCIAL SERVICE/ANCILLARY HEALTH PROVIDERS – Section F

ASO Name:		Phone:
Address:		
City	County	Zip
ASO Case Manager:		
ASO CM Phone:	ASO CM e-mail:	ASO CM Other:

PAC Waiver Services – Section G

	Adult Dental		Homemaker		Specialized Care Foster Child
	Case Management		Nutritional Risk Reduction		Other
	Chore – Pest Control		Personal Care		Other
	Chore - Other		Skilled Nursing – RN/LPN		
	Day Health Care		Specialized Medical Equipment		
	Education and Support		Medical Supplies		
	Environmental Adaptations		Therapeutic Mgmt Substance		
	Home Delivered Meals		Restorative Massage		

Assistance Benefits – Section H

	Cash Assistance		OSS		Private disability
	SSI		Unemployment		ADAP
	Medicaid		Medicare		Veterans Medical
	Indian Medical Services		Food Stamps		Veterans Pension
	Private Retirement		Life Insurance		Insur. Continuation (ICAP)

Assistance Benefits Detail – Section I			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			
Benefit Provider Name:			
Address:	City	State	Zip
Type of Benefit:	Policy Number:		
Contact Person	Phone		
Comment:			

Mental Health/Life Habits Information – Section J		
Are you currently seeing a mental health provider?	YES:	NO:
Type of provider: ☐ Psychiatrist ☐ Psychologist ☐ LCSW ☐ MFCC ☐ MSW ☐ Group ☐ Other:		
Provider Name:	Phone	
Address:	City: Zip	
E-mail:	Access to Chart: ☐ YES ☐ NO	

Symptoms					
Are you currently experiencing any of the following: (check if present)					Increased sadness?
	Increased tearfulness?		Sleep disturbance?		Feeling of helplessness/hopelessness
	Decrease sex drive?		Loss/decrease energy?		Loss of interest in usual/favored activities
	Low self esteem?		Difficulty concentrating?		Feelings of guilt?
If client is experiencing 5 or more of these symptoms, he/she may be depressed. Contact PCP for Mental Health referral.					

✔	Current Therapy For –Section K				
	Anxiety		Bipolar		Substance Abuse
	Depression		Panic Disorder		OCD
	Grief		Schizophrenia		Other:

Comment:

Exercise – Section L

✔	Exercise Routine	Frequency	Duration
	None		
	Walking		
	Bike Riding		
	Aerobic		
	Weight Training		
	Swimming		
	Jogging		
	Calisthenics		
	Other:		
	Other:		

Diet and Nutrition - Section M

Current Weight:	Height:	Ideal Body Weight:
Recent Weight Loss/Gain: ☐ Yes ☐ No	Amount Loss/Gain:	Period of time:
Intentional Loss/Gain: ☐ Yes ☐ No	Comment:	

Body Fat/Bone Density Measurement – Section N

"	Waist	"	R Upper Arm	"	Abdomen	"	R Thigh
"	Hips	"	L Upper Arm	"		"	Facial Wasting
"	Chest	"	L Thigh	"		"	"Buffalo Hump"

BIA Done: ☐ Yes ☐ No	BIA Result:	Date BIA Done:
Bone Density Done: ☐ Yes ☐ No	BD Result:	Date BD Done:

Diet – Section O

Special Diet: ☐ Yes ☐ No	Diet Type:
Restrictions:	
Supplements Taken: ☐ Yes ☐ No	Supplement Type:

Vitamins/Minerals Taken:	Frequency:
Vitamins/Minerals Taken:	Frequency:
Vitamins/Minerals Taken:	Frequency:
Herbals Taken:	Frequency:
Herbals Taken:	Frequency:
Herbals Taken:	Frequency:

Food Allergies:

Usual Water per day: ☐ 1-3 glasses ☐ 4 – 6 glasses ☐ 7- 9 glasses ☐ 10 – 12 glasses ☐ None

Comments:

Activities of Daily Living – Section P						
Activity	**Independent**	**Minimal Assist**	**Maximum Assist**	**Dependent**	**PAC Waiver**	**Comment**
Bathing						
Oral Hygiene						
Toileting						
Grooming						
Dressing						
Ambulate						
Cook						
Feed Self						
Use Phone						
Clean Home						
Drive						
Use Public Transportation						
Transfer self- bed/chair, chair/car, etc.						
Pay bills						
Grocery Shop						
Sight						
Hearing						
Reading						
Speech						
Medication Administration						
Medical Testing (eg. BGM, B/P)						
Medical Treatment (eg. Dressings, etc.)						
Child Care						
Fill Out Forms						
Other:						

Section #	Comments Related to Information Collected

Medical/Ancillary Health Provider Information – Section Q			
MediPass Primary Care Provider			
Primary Care Provider:			Category: MD, DO, RNP, PA
Address			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing MediPass PCP: ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Attending Provider			
"Attending Provider"			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing : ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Specialty Medical Provider(s)			
Provider:			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing : ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:		Access to Medical Record: ☐ YES ☐ NO	
Additional Medical Provider			
Provider:			Category: MD, DO, RNP, PA
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:		E-Mail:
Specialty:	Medical Group Name:		
Currently Seeing : ☐ YES ☐ NO		Last Visit:	
Reason for Last Visit:			
Comment:			
Access to Medical Record:			
Dental Care Provider			
Name:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : ☐ YES ☐ NO	Last Visit:	Reason:	
Frequency of visits:			
Comment:		Access to Medical Record: ☐ YES ☐ NO	

Medical/Ancillary Health Provider Information – Section Q Continued			
Ancillary Health Provider			
Name:			
Type: ☐Home Health Skilled Nursing ☐ Physical Therapy ☐ Respiratory Therapy ☐ Other:			
Address			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing: ☐ YES ☐ NO	Last Visit:		
Reason for Last Visit:			
Comment:	Access to Medical Record: ☐ YES ☐ NO		
Ancillary Health Provider			
Name:			
Type: ☐Home Health Skilled Nursing ☐ Physical Therapy ☐ Respiratory Therapy ☐ Other:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : ☐ YES ☐ NO	Last Visit:		
Reason for Last Visit:			
Comment:	Access to Medical Record: ☐ YES ☐ NO		
Pharmacy			
Name:			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Filling All Prescriptions: ☐ YES ☐ NO	Last Fill:		
Refills all on same schedule: ☐ YES ☐ NO	Do you call for Refills?: ☐ YES ☐ NO		
Are Refills Done Automatically by Pharmacy: ☐ YES ☐ NO	Pharmacist Name:		
Access to Pharmacy Profile: ☐ YES ☐ NO Comment:			
Payer Source: ☐ Medicaid ☐ ADAP ☐ Veterans ☐ Indian Affairs ☐ Private Plan ☐ Cash ☐ Other			
Comment:			
Additional Pharmacy			
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Filling All Prescriptions: ☐ YES ☐ NO	Last Fill:		
Refills all on same schedule: ☐ YES ☐ NO	Do you call for Refills?: ☐ YES ☐ NO		
Are Refills Done Automatically by Pharmacy: ☐ YES ☐ NO	Pharmacist Name:		
Access to Pharmacy Profile: ☐ YES ☐ NO Comment:			
Payer Source: ☐ Medicaid ☐ ADAP ☐ Veterans ☐ Indian Affairs ☐ Private Plan ☐ Cash ☐ Other			
Comment:			
Other Ancillary Health Provider			
Name:		Type:	
Address:			
City:	County:	Zip:	Region:
Phone:	FAX:	E-Mail:	
Currently Seeing : ☐ YES ☐ NO	Last Visit:	Reason:	
Comment:	Access to Medical Record: ☐ YES ☐ NO		

MEDICAL HISTORY – Section R

ALLERGIES:

HIV History

First HIV Positive Date:		Source: ☐ Client Self Report ☐ Medical Record	
Most Recent Viral Load Date:	Result:	Most Recent CD4 Date:	Result:
Highest VL Date:	Result:	Lowest CD4 Date:	Result:

Source = C (Chart) P (Patient Reports) **Opportunistic Diseases and/or Complications**

Source	Onset ✔	Resolved ✔	Condition	Source	Onset ✔	Resolved ✔	Condition
			Pneumocystis carinii pneumonia (PCP)				HIV Encephalopathy
			Esophageal Candidiasis				Other neuro manifestations, eg. Peripheral neuropathy
			Kaposi's Sarcoma				Cardiomyopathy (CHF or cor pulmonale or other abn. Not responsive to treatment
			HIV wasting disease (>10% wt loss)				Nephropathy resulting in chronic renal failure
			Mycobacterium avium complex (MAC)				Infections resistant to treatment/requiring hospitalization or IV's 3x/year (e.g. sepsis,menigitis, pneumonia, septic arthritis, endocarditis, sinusitis)
			Cytomegalovirus disease (eyes)				Anemia (Hct @30% or <
			Cytomegalovirus disease (GI)				Granulocytopenia ANC < 1000 recrurrent bacterial infection 3x in 5 mo
			Cytomegalovirus disease (Disseminated)				Cancer of Cervix, invasive FIGO Stage II and >
			AIDS Dementia Complex				Thrombocytopenia Platelets<40K repeatedly with spontaneous bleed
			Cryptococcosis				Diarrhea lasting > 1 mo, resistant to treatment
			Non-Hodgkin's lymphoma				Cholesterol abnormalities
			Toxoplasmosis				Triglyceride abnormalities
			Cryptosporidiosis				Diabetes
			Chronic herpes simplex infection				Insulin resistance
			Recurrent bacterial pneumonia				Fat Maldistribution
			Tuberculosis				Osteoporosis
			Multiple vaginal infections				Osteopenia
			PML				Osteomalacia
			Cholesterol abnormalities				Lactic Acidosis
			Aspergillosis				Pancreatitis
			Histoplasmosis				Microsporidiosis
			Isosporiasis				Strongyloidiasis (extra-intestinal)
			Other:				Other:

CDC AIDS Case Definition Categories

✔	CD4 Cell Categories	✔	**A:** Asymptomatic or PGL or Acute HIV Infection	✔	**B:** Symptomatic (not A or C)	✔	**C:** AIDS Indicator Condition
	1. > 500/mm³ (29%)		**A1**		**B1**		**C1**
	2. 200 to 499/ mm³ (14% to 28%)		**A2**		**B2**		**C2**
	3. <200/ mm³ (14%)		**A3**		**B3**		**C3**

*** All patients in categories A3, B3, and C1-3 are defined as having AIDS based on the presence of an AIDS indicator condition and/or a CD4 cell count < 200/mm³**

ARV THERAPY HISTORY

Currently taking ARV Regimen: ☐ YES ☐ NO	**IF NO, WHY?:** ☐ Refused ☐ CD4> 500
☐ CD4 > 350, VL < 55,000(PCR) or <33,000 (b DNA)	☐ Other:

ARV THERAPY HISTORY								
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**NRTIs**		**Dose**	**Frequency**	**DC Reason**
				Zidovudine	Retrovir (AZT)			
				Didanosine	Videx (ddI)			
				Zalcitabine	Hivid (ddC)			
				Stavudine	Zerit (d4T)			
				Lamivudine	Epivir (3TC)			
				Abacavir	Ziagen (ABC)			
				Combivir	AZT + 3TC			
				Trizivir	AZT+3TC+ABC			
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**NNRTIs**		**Dose**	**Frequency**	**DC Reason**
				Nevirapine	Viramune (NVP)			
				Delavirdine	Rescriptor (DLV)			
				Efavirenz	Sustiva (EFV)			
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**PROTEASE INHIBITORS**		**Dose**	**Frequency**	**DC Reason**
				Indinavir	Crixivan (IDV)			
				Ritonavir	Norvir (RTV)			
				Saquinavir	Invirase, Fortovase (SQV)			
				Nelfinavir	Viracept (NFV)			
				Amprenavir	Agenerase (APV)			
				Lopinavir/ritonavir	Kaletra (ABT/378/R, LPV/RTV)			
Pt. Taking	**Pharm Filling**	**Start**	**Stop**	**INVESTIGATIONAL DRUGS**		**Dose**	**Frequency**	**DC Reason**
				NRTI	Emtricitabine	200mg	QD	
				NRTI	DAPD	300-500 mg	BID	
				NRTI	Tenofovir	300mg	QD	
				NNRTI	Capravirine	700-1200 mg	BID	
				NNRTI	TMC120	50-100 mg	BID	
				PI	BMS-232632	200-500 mg	QD	
				PI	Tipranavir	300-1200mg + 200mg Ritonavir		
				BFI*	T-20	50-100 mg	BID	
				BFI*	T-1249	6.25-50 mg	QD or BID	
				BFI*	PRO 542	0.2 10.0 mg/kg IV		

*** BFI = Binding/ Fusion Inhibitors**

PRIMARY INVESTIGATOR IF ON INVESTIGATIONAL DRUGS	
P.I. Name:	
Study:	
Study Location:	
Study Coordinator:	**Phone:**

PROPHYLACTIC MEDICATIONS				
Start	**Stop**	**Medication**	**Recommendations**	**Disease Prevention**
		TMP/SMX 1DS/day or 1 SS/day or 3DS/week	<200-250 CD4	PCP
		Fluconazole 100-200mg/day PO	High risk pt with <50 CD4	Crypto, Coccidio
		TMP/SMX 1 DS/day PO	+ Toxo IgG with CD4<100	Toxoplasmosis
		Cytovene 1 g PO tid	<50 CD4	CMV
		Clarithromycin 500 mg qd or bid	<50 CD4	MAC

NON-ARV MEDICATION PROFILE							
Start	**Stop**	**MD RX**	**Filled**	**Medication**	**Dose**	**Frequency**	**DC Reason**

MEDICAL HISTORY					
✔	**Co-morbid Conditions**	✔	**Co-morbid Conditions**	✔	**Co-morbid Conditions**
	Abnormal PAP		Diabetes Type I		OCD
	Anemia		Diabetes Type II		Paralysis
	Anxiety:		Eczema		Psoriasis
	Arthritis		Erectile dysfunction		Schizophrenia
	Asthma		ETOH Use		Seizures
	Bronchitis		GERD (Gatroesoph Reflux)		Sleep problems
	CHF		Hepatitis A		Smoking:
	Cirrhosis		Hepatitis B		Thyroid abnormalities
	Constipation		Hepatitis C		TMJ
	COPD		Hypertension		Urinary Incontinence
	Depression		Kidney Failure		Vaginal Bleeding
Other Medical History Conditions:					

SYSTEM REVIEW HISTORY – Section S						
Vital Signs	B/P:	P:	R:	T:	Weight:	Height:
Head & Neck						
Eyes						
Chest & Lungs						
Cardiovascular						
Breast						
Pelvic						
Abdominal (GI)						
Kidney & Urinary						
Back & Extremity						
Neurologic						
Mental Status						
Oral/Dental						
Other System History Information:						

GYN HISTORY – Section T			
LMP:	Gravida:	Para:	Births since HIV+:
HIV + Children:		Desire Children:	
Last PAP Smear Date:		Results:	
Birth Control Method: ☐ Rhythm Method ☐ Barrier ☐ Birth Control Pills ☐ Abstinence ☐Other:			
Menopause Onset Date:		Estrogen Replacement:	

IMMUNIZATION HISTORY – Section U			
Date	**Immunization**	**Date**	**Immunization**
	Dip Tet		Pneumococcal CD4 when given:
	MMR		Influenza
	Polio		Varicella
	Hepatitis B		Other:
	Hepatitis A		Other:

SUBSTANCE USE HISTORY – Section V				
✔	**Substance**	**Amount**	**Frequency**	✔ **if currently using**
	Alcohol*			
	Opiates			
	Marijuana			
	Cocaine/Crack			
	Speed/Amphetamines			
	PCP			
	GHB			
	Ecstacy*			
	Methadone			
	Fentenyl Patch			
	OxyContin			
	Crystal Meth			
	"Special K" *			
	Other:			
* Significant drug/drug interaction with PIs.				
If actively using, is client interested in stopping? ☐ YES ☐ NO				

LIVER DISEASE HISTORY – Section W			
Hepatitis B			
Have you had Hepatitis B: ☐YES ☐ NO ☐ UNKNOWN If YES DATE DIAGNOSED:			
Test	**Date**	**Result** **Positive ✔ / Negative ✔**	**Source of Info** **Chart ✔ / Patient ✔**
Anti-HBc (Hepatitis B Core Antibody)			
Anti-HBs (Hepatitis B Surface Antibody)**			
HBsAg (Hepatitis B Surface Antigen)			
** If recently vaccinated, Anti-HBs needs to be done 1 to 6 months after the last dose of vaccine.			

Hepatitis B Vaccine					
Date Given	**Vaccine**	**Date Due**	**Date Given**	**Vaccine**	**Date Due**
	Hepatitis B Vaccine 1cc dose #1			Hepatitis B 1cc dose #3	
	Hepatitis B Vaccine 1 cc dose #2			HbsAb Test to verify	

Hepatitis B Treatment History					
Start Date	**Stop Date**	**Treatment**	**Result**	**Source of Info Chart ✔ / Patient ✔**	
		Epivir 150 mg bid (HIV) or 100mg/day (HBV)			
		Interferon 30-35 mil units/wk x 4 mo			
		HARRT therapy with no anti-HBV agents			
		Nothing			
		Other:			
		Epivir+ famciclovir 500mg bid or tid to decrease resistance to Epivir. *(Experimental)*			

Hepatitis C						
Do you have Hepatitis C: ☐YES ☐ NO ☐ UNKNOWN If YES DATE DIAGNOSED:						
Test	**Date**	**Approximate $**	**Result Positive ✔ / Negative ✔**		**Source of Info Chart ✔ / Patient ✔**	
EIA for Anti-HCV		25 – 45				
RIBA for Anti-HCV		115 – 150				
RT-PCR for HCV RNA		160 – 200				
HCV PCR (Quantitative RNA)		160 – 225				
Genotype		200 – 250				

Hepatitis C Treatment History					
Start Date	**Stop Date**	**Treatment**	**Result**	**Source of Info Chart ✔**	**Patient ✔**
		Hepatitis A vaccine if HAV sero-negative			
		Alpha interferon, 3 million units SC 3x/wk plus Ribavirin 1000 – 1200 mg/day PO x 24 wks for genotype 2&3 or 48 wks for genotype 1			
		Peginterferon alfa 2, or alpha 2b (PEG-Intron), 1.0-1.2 mg/kg q wk SC; both should be combined with ribavirin 10.6 mg/kg/day x 48 weeks			
		Nothing			
		Other:			

Hepatitis A					
Have you had Hepatitis A: ☐YES ☐ NO ☐ UNKNOWN If YES DATE DIAGNOSED:					
Test	**Date**	**Result Positive ✔ / Negative ✔**		**Source of Info Chart ✔ / Patient ✔**	
Anti-HAV (IgG)					

Hepatitis A Prophylaxis History			
Date Given	**Treatment**	**Chart ✔**	**Patient ✔**
	Havrix 0.5 mL IM x 2 separated by 6 months		
	Havrix 0.5 mL IM second dose		

PAIN HISTORY – Section X						
Question	**Yes**	**No**	✔	**Pain Characteristics**	✔	**Pain Characteristics**
Do you currently have pain?				Constant		Dull, aching
Pain Scale		**#**		Intermittent		Burning
Scale of 1-10, 10 being worst:				Sharp		Tingling
Location of Pain:				Stabbing		Numbness

PAIN MEDICATIONS				
✔	Medication	Dose	Frequency	Effective ✔
	ASA, Acetominophen			
	Codeine			
	Demerol			
	Dilaudid			
	Methadone			
	MS Contin			
	OxyContin			
	Fentanyl Patch			
	Ultram			
	NSAIDS			
	Neurontin			
	Lortab:			
	Vicodin:			
	Other:			
	Other:			

Sexually Transmitted Diseases – Section Y							
Onset	Treated	Resolved	Infection	Onset	Treated	Resolved	Infection
			Syphilis				Chancroid
			Gonorrhea				Herpes
			LGV (Lymphogranuloma venerium)				Rectal Warts
			HPV (Genital Warts)				Trichomonas
			Condyloma				Other
			Chlamydia				Other
STD Comments:							

Prosthesis and/or Implanted Devices							
✔		✔		✔		✔	
	Hearing Aid		PortaCath		Pacemaker		
	Glasses		Triple lumen catheter				
	Dentures		PICC line				

LABORATORY RESULTS – Section Z									
(Record the most recent test available and the date done)									
Lab Name:									Write in Lab Name on this line
Test	Date	Result	Date	Result	Date	Result	Date	Result	Recommend Frequency
HIV Ab									Initial
CD4 Absolute									Q 3 to 6 MONTHS
CD4 %									Q 3 to 6 MONTHS
Viral Load									Q 3 to 6 MONTHS
Hemoglobin									Q 3 to 6 MONTHS
Hematocrit									Q 3 to 6 MONTHS

LABORATORY RESULTS – Section Z									
(Record the most recent test available and the date done)									
Lab Name:									**Write in Lab Name on this line**
Test	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Recommend Frequency**
WBC									Q 3 to 6 MONTHS
RBC									Q 3 to 6 MONTHS
Platelets									Q 3 to 6 MONTHS
ANC									Q 3 to 6 MONTHS
K									Initial and PRN as appropriate
Na									Initial and PRN as appropriate
Cl									Initial and PRN as appropriate
CO2									Initial and PRN as appropriate
FBS									2 mo. After starting PI and q 3 to 4 months
BUN									
Creatinine									
Bilirubin									
AST									Base & 24 wks after initiation of tx
ALT									Base & 24 wks after initiation of tx
Albumin									Base & 24 wks after initiation of tx
Alk Phos									Base & 24 wks after initiation of tx
GGT									Base & 24 wks after initiation of tx
Lipase									Per Symptoms
Amylase									Per symptoms
Lactic Acid									Per Symptoms
VDRL/RPR									Q Year or PRN by history
LDH									Per Symptoms
CPK									Per Symptoms
Cholesterol									Base and Q 3 to 6 Mo

LABORATORY RESULTS – Section Z									
(Record the most recent test available and the date done)									
Lab Name:									**Write in Lab Name on this line**
Test	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Date**	**Result**	**Recommend Frequency**
LDL									Base and Q 3 to 6 Mo
HDL									Base and Q 3 to 6 Mo
Triglycerides									Base and Q 3 to 6 Mo
PAP Smear									Q 6 months
PPD TB Test									Annual if previous neg
CXR									Per Sx or new + PPD
CMV IgG									Optional baseline, when sx
Toxoplasma IgG									Base screen. Repeat if <100 CD4 or symptomatic
Genotype									Suspected resistance
Phenotype									Suspected resistance
ARV Drug Level: _____									Suspected resistance
G6PD									Baseline for risk population
Hgb A1c									
INR									

INITIAL ASSESSMENT	
Section if applicable	**CARE MANAGER COMMENTS**

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
	Marital Status					
	Single					
	Married					
	Widowed					
	Separated					
	Divorced					
	Domestic partner					
	Dependents (Select only 1 answer)					
	No Dependents					
	Children over 18					
	Children > 5 years at home					
	Children < 5 years at home					
	Support System (Select those that apply)					
	Alone - no friends or family					
	Lives alone some friends					
	Lives alone family close by					
	Lives with friends/family--no support					
	Lives with friends/family--adequate support					
	Others in the home **Do Not** know of HIV status					
	Housing (Select only 1 answer)					
	Lives alone apartment or house					
	Lives with others--permanent					
	Lives with others--temporary					
	Lives at a shelter					
	Lives in a supervised facility					
	Homeless					
	Utilities (Select all that apply)					
	No Phone					
	No Water					
	No Gas--if needed for cooking or hot water					
	No electricity					
	Appliances (Stove/Refrigerator)					
	Missing stove					
	Missing refrigerator/freezer					
	Transportation (Select only 1 answer)					
	Dependant on Bus/Taxi					
	Has own transportation					
	Has third party funded transportation					
	Has access to transportation--family/friend					
	Unable to Access Public Transportation					

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
	Income					
	None					
	<10K income and or benefits					
	10K--20K income and benefits					
	>20K in income and benefits					
	Employment (Select all that apply)					
	Employed (Part-time or Full-time)					
	Unemployed					
	Disabled					
	Benefits (Select only 1 answer)					
	No benefits					
	1--2 benefits					
	3--6 benefits					
	> 6 benefits					
	Education (Select all that apply)					
	None					
	K-6					
	7-12					
	> 12 years of school					
	reads and writes English					
	reads and writes another language					
	does not read or write any language					
	No Mailings					
	Language (Select only 1 answer)					
	Primary language is English					
	English as a second language (ESL)					
	Does not speak English					
	Mental Health Risk					
	Exhibits mental health challenges--not in care					
	Exhibits mental health challenges--in care					
	No mental health issues apparent					
	Refuses mental health care					
	Health Risk Behaviors (Select all that apply)					
	Overweight					
	Active substance abuse					
	Non-Adherence to Treatment Regimen					
	ETOH abuse					
	Smoking tobacco and/or chewing tobacco					
		No			**Yes**	
	Practices unsafe sex					

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

Acuity Determination Tool

Social Demographic Findings from Assessment			0	1	2	3	Comment
	Diet and Nutrition						
	Weight appropriate for height						
	< 90% of Ideal Body Weight						
	> 10% Unintentional Weight Loss						
	CD4 & Viral Load						
	CD4 > 500						
	CD4 499 - 350						
	CD4 349 - 51						
	CD4 < 50						
	Viral Load						
	Undetectable						
	51 - 10,000						
	10,001 - 19,999						
	> 20,000						
	Absence of Antiretroviral Therapy (1 answer only)						
	CD4 < 350 regardless of VL						
	CD4 350 - 500 & VL >5,000						
	CD4 > 500 & VL >30,000						
	Past and Present Medical History						
	Hospitalizations, OI's and Co-Morbid conditions--1 pt each						
	Cancer--in the past						
	Pain	0-2					
		3-5					
		6-8					
		9-10					
	Current Medication Regimen						
	Currently not prescribed any medications						
	Currently taking antiretrovirals only						
	Taking both antiretrovirals and other meds						
	Taking other medication (Non ARV)						

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

Acuity Determination Tool

Social Demographic Findings from Assessment		0	1	2	3	Comment
Activities of Daily Living						
	(Select the most appropriate answer)	Independent	Minimal Assist	Max Assist	Dependent	
	Personal Hygiene					
	bathing					
	oral hygiene					
	toileting					
	grooming					
	dressing					
	Nutritional Status					
	grocery shopping					
	cooking					
	feed self					
	Activity					
	ambulate (walking)					
	transfers (if using devices)					
	driving					
	use public transportation					
	clean home					
	child care					
	pay bills					
	can use phone					
	fill out forms					
	medication administration					
	medical testing--BGM or BP					
	medical treatment--dressings					
	Sense impairment	No	Yes			
	Sight					
	Hearing					
	Reading					
	Speech					

Scoring Methodology	1 - Low	2- Medium	3 - High
	0-24	25-35	>36

Client Name: _____ RNCM: _____

ID#: _____

Date:_____

POSITIVE HEALTHCARE

Name: **Acuity Determination Tool**		
Approved By:	Date: September 2002	No:
Director PHC Florida _____ Chief of Managed Care	Review Date: May 14, 2004 Revised Date: May 14, 2004	

POLICY:

The Acuity Determination Tool (ADT) will be used in conjunction with the AHF/Positive Healthcare Initial Assessment/Reassessment Tool to assist the RN Care Manager (RNCM) in determining a client's level of need.

PROCEDURE:

Upon completion of the Initial/Reassessment, the RNCM will:

1. Determine a preliminary acuity based on their clinical judgment.
2. Complete a preliminary acuity form and give it to the PAC Case Manager immediately following the assessment.
3. Enter the assessment within 30 days and provide a computer generated final acuity level which based on the following scores:

    0-24 = Severity Level 1
    25-35 = Severity Level 2
    36 or greater = Severity 3

The RNCM has the authority to override the severity level assigned according to scale; the reason must be justified in a progress note and written on the computer generated acuity form.

Project AIDS Care Preliminary Acuity Determination

The preliminary acuity level assigned to this patient is a ____. This is based on a face-to-face medical needs assessment only. The final acuity level is pending a medical record review at the provider's office and a Plan of Care meeting with the primary care provider and other members of the healthcare team, including the case manager.

Once this is complete, you will receive final acuity level determination for your records.

Thank you,

AHF/Positive Healthcare
RN Care Manager

Patient name: _____

Medicaid ID#: _____

Date assessed: _____

POSITIVE HEALTHCARE

Acuity Determination Tool

Patient :

ID: Enrolled Date: 9/1/2003

Assessment Date: 12/8/2003

Care Manager:

1. Social Demographics: Total		**3**
Marital Status:	Domestic Partner	0
Multiple dependents	No	0
Children:	No	0
Housing:	Alone	2
Support System	Friends	
Income:	$10K-$20K	1
Education:	Some College	0
Written Materials:	English	0
Primary Language:	English	0
Mailings:	Education/PHC/Thrive	0
Unsafe Sex:	Condoms Always	0
2. Living Environment: Total		**4**
Dwelling Type:	Apartment	0
Phone:	Yes	0
Water:	Yes	0
Gas:	No	2
Electricity:	Yes	0
Stove:	Yes	0
Refrigerator:	Yes	0
Transportation:	Public	2
HIV Status Known:	N/A	0
3. Employment		
Employment:	No	3
Disabled:	Yes	1
4. Assistance benefits		
Benefits:	1 - 2	2
5. Body Measurements		
Weight:	Appropriate for Height	0
6. Active Substance Abuse		
Currently Using:	Yes	3
7. Tobacco		
Currently Using:	No	0
8. Mental Health Risk		
Challenges:	Yes, In Care	1
Mental Health Care:		
9. Pain		
Pain Scale:	3-5	1

10. Daily Living Activities: Total		**1**
Personal Hygiene:	Total	0
Bathing:	Independent	0
Oral Hygiene:	Independent	0
Toileting:	Independent	0
Grooming:	Independent	0
Dressing:	Independent	0
Nutritional Status:	Total	1
Grocery shopping	Independent	0
Cooking:	Minimal Assistance	1
Feed self:	Independent	0
Activity:	Total	0
Ambulate:	Independent	0
Transfers:	Independent	0
Driving:	Independent	0
Public Transport.	Independent	0
Clean Home:	Independent	0
Child Care:	None	0
Pay Bills:	Independent	0
Use Phone:	Independent	0
Fill Out Forms:	Independent	0
Medical Admin.:	Independent	0
Medical Testing:	Independent	0
Medical Treatm.:	Independent	0
Sense Impairment:	Total	0
Sight:	Yes	0
Hearing:	Yes	0
Reading:	Yes	0
Speech:	Yes	0
11. Current Medication Regimen		
Medications:	ARV, Non-ARV, Prophylactic	3
12. Past and Present Medical History		
Diagnosis:	Current Co-Morbid conditions	3
Cancer:	No Current Records	0
13. Lab Results		
CD4 Abs.:	Last Result: 345.00	2
Viral Load:	Last Result: 1,050.00	1
14. Absence of ARV Therapy		
ARV Meds:	Are Currently Present	0

Total Result: 28

Severity Level is equal: 2

APPENDIX F

PLAN OF CARE SUMMARY

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PAC WAIVER PLAN OF CARE (POC) SUMMARY **APPENDIX F**

Recipient's: Name_____ Medicaid ID #_____ Phone #_____ Caregiver_____

POC-Begin:_____ POC-End:_____ LOC Effective Date:_____ Case Management Agency_____

Case Manager:_____ Phone #:_____ Physician Name:_____

PROCEDURE CODE	PROCEDURE DESCRIPTION	BEGIN DATE	END DATE	AUTHORIZED PROVIDER NAME & MEDICAID ID #	FREQUENCY WEEK/MONTH	UNIT COST	TOTAL COST/MONTH

Exception Request Approved by:_____ Date:_____ Total PAC Waiver funds per month_____

NON-PAC WAIVER SERVICES PROVIDED BY THIRD PARTIES, MEDICARE, MEDICAID OR OTHER FUNDING SOURCES

SERVICE	PROVIDER	FUNDING SOURCE AND COMMENTS

NOTE: The recipient/representative has been provided with an explanation and a choice of providers for the services in the Plan of Care. The recipient/representative has been given a copy of the Plan of Care on ___/___/___.

The Plan of Care was reviewed by the Care Manager: Signature of Care Manager:_____ Date: _____

Signature of Case Manager _____ Signature of PAC recipient/representative: _____ Date: _____

APPENDIX G

SERVICE AUTHORIZATION

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PROJECT AIDS CARE (PAC) WAIVER SERVICE AUTHORIZATION

PAC Waiver Claim Authorization Number: _ _ _ _ _ _ _ _ _

Service Provider Name: _____ **and Medicaid Number:** _____

Authorized Maximum Billable Amount per Month: $_____

Unauthorized services and services beyond the amount, duration and scope authorized by the case manager will be subject to recoupment from the service provider.

RECIPIENT INFORMATION

Recipient Name: _____ DOB: _____ Sex: ____

Address: _____ City: _____

Medicaid ID: _____ Phone #: _____

Procedure Code	Service Description	Not to exceed six months		# of Units	Per D/W/M	Maximum Amount
		From	To			
						$
						$
						$
						$

SPECIAL INSTRUCTIONS:

The above services are authorized for _____ (PAC recipient name).

_____

_____

_____

_____

_____

PRINT NAME OF CASE MANAGEMENT AGENCY:_____

PRINT NAME OF CASE MANAGER: _____ Phone: _____

SIGNATURE OF CASE MANAGER: _____ Date: _____

INSTRUCTIONS

- The Case Manager must notify providers that services have been authorized by using the PAC Waiver Service Authorization form.
- The case manager must authorize services contained in the current plan of care.
- The case manager must document the need for the service in the case narrative.
- The service provider must be qualified as per the Provider Qualifications in Chapter 1 of the PAC Waiver Services Coverage and Limitations Handbook.
- The service provider must receive a signed and completed Service Authorization form from the case manager, before providing the services.

THE FOLLOWING EXPLAINS ITEMS ON THE SERVICE AUTHORIZATION FORM.

ITEM	DESCRIPTION
■ Claim Authorization Number	The case manager's provider number. Enter in the "Referring Provider" block of the 081 claim form.
■ Service Provider Name	Name of provider.
■ Service Provider Number	Provider's PAC Medicaid Provider Number.
■ Authorized Maximum Billable	The maximum that can be reimbursed for one month.
■ Recipient Name	Recipient's name.
■ DOB	Recipient's date of birth.
■ Sex	Recipient's gender.
■ Address	Recipient's address.
■ Medicaid ID:	Recipient's Medicaid identification number.
■ Phone	Recipient's phone Number.
■ Agency Name	Case management agency name.
■ Phone	Case management agency phone number.
■ Procedure Code	PAC Waiver procedure code for service authorized.
■ Service Description	Brief description of service authorized.
■ From	Start date of service authorized.
■ To	End date of service authorized.
■ # of Units	Number of units of service authorized.
■ Per D/W/M	Frequency of authorized services delivered per day (**D**), per week (**W**) or per month (**M)**.
■ Maximum Amount	The authorized maximum billable amount for an authorized service for the duration specified on the form.
■ Special Instructions	Any special instructions, such as directions to the recipient's home, circumstances to be expected and any other helpful suggestions for the provider.

APPENDIX H

REQUEST FOR PLAN OF CARE EXPENDITURE EXCEPTION

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REQUEST FOR PLAN OF CARE EXPENDITURE EXCEPTION

Case Management Agency:_____ Medicaid Provider ID#:_____

Case Manager:_____ Phone:(__)_____ Fax: (__)_____

Recipient's Medicaid ID #:_____ Date of Birth:_____

Provide a brief type written narrative that describes the following:

Recipient's current medical condition. Include functional limitations and opportunistic illnesses.	
Reason and justification for additional expenditures, including anticipated outcomes.	
Please check the documentation included.	☐ Physician's Prescription **Current:** ☐ Level of Care (CARES) ☐ Plan of Care ☐ Social Needs Assessment Acuity Level: ☐ Low ☐ Moderate ☐ High Itemized cost list and work orders* for ☐ Environmental Accessibility Adaptations ☐ Specialized Medical Equipment and Supplies ***** Include a description of the item(s), quantity, manufacturer/model/serial number/parts and special features if applicable, comparable market cost per unit and total cost.

Duration of Request (Max. of 6 months)	Begin Date _____ End Date _____
Comments (Attach additional pages if needed)	

I certify to the best of my knowledge all of the statements contained herein are true, complete and made in good faith.

Signature of Case Manager:_____ Date: _____

Medicaid Provider ID# of Case Manager:_____

TO BE COMPLETED BY DISEASE MANAGEMENT ORGANIZATION (DMO) STAFF

The request has been:

☐ **Approved for duration of _____ to _____**

☐ **Partially approved for duration of _____ to _____**

☐ **Denied**

☐ **Returned**

Comments:

Signature of DMO Regional Manager:_____ Date:_____

PAC WAIVER EXCEPTION REQUEST PROCESS

A completed **Request for Plan of Care Expenditure Exception** must be submitted to the regional office of the Disease Management Organization (DMO) for AIDS, when:

- The total costs for PAC waiver services exceed $1000 per month.
- Services not included under recipient's assessed Acuity Level***** are needed.
- Services are needed in excess of maximum limits.

The case manager submits a completed Request for Plan of Care Expenditure Exception form and supporting documentation to the Regional Office for the DMO.

Staff at the DMO will date stamp the form on receipt and review it for completeness. Requests that are incomplete will be returned to the case manager within 5 working days with a note describing the additional documentation needed.

The DMO staff will review requests that are complete and have adequate supporting documentation. The request will be processed and determined as Approved, Partially Approved or Denied. The written determination will be sent to the Case Manager within 5 working days and copied to the Medicaid PAC waiver liaison and the PAC waiver program analyst at headquarters.

If approved, the Case Manager will proceed to update the plan of care and coordinate access to the authorized services.

The DMO will track the requests that are received and submit monthly reports to the PAC waiver program analyst on the number and nature of the requests that were submitted, and outcomes.

Note: *****_Acuity Levels_ are determined following the completion of a Comprehensive Needs Assessment that is comprised of a Social Needs Assessment and a Medical Needs Assessment.

Comprehensive Needs Assessments are completed when a recipient:

- Is new to the PAC Waiver and does not have an Acuity Level; or
- Has a changed health status that requires a re-evaluation of their Acuity Level; or
- Has not had a Comprehensive Needs Assessment within the last 12 months and has not received an Acuity Level.

APPENDIX I

ACUITY LEVELS AND PAC WAIVER SERVICES

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ACUITY LEVELS AND PAC WAIVER SERVICES

Exception Requests: Shaded blocks indicate services that are not available under a particular acuity level. Exception Requests may be submitted when a service is needed that is not indicated for that acuity level, or is needed more than the maximum limits.

Non-Duplication of Services: PAC Waiver Services may not duplicate services available through other funding sources or Medicaid State Plan programs.

SERVICE	LEVEL I LOW ACUITY	LEVEL II MODERATE ACUITY	LEVEL III HIGH ACUITY
CASE MANAGEMENT	Consumer contact every 2 months. Face-to face contact every 6 months.	Consumer contact every month. Face-to face contact every 3 months.	Consumer contact every 2 weeks. Face-to face contact every month.
CHORE - PEST CONTROL	When needed.	When needed.	When needed.
CHORE - OTHER		When needed.	When needed.
DAY HEALTH CARE		When needed.	When needed.
EDUCATION AND SUPPORT	Available for 3 months from enrollment.	Available for 6 months from enrollment or in crisis.	Available for on-going needs.
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS		Available to homeowners to promote greater independence.	Available to homeowners to promote greater independence.
HOME DELIVERED MEALS		Prescribed by physician and when no in-home support is present for up to 2 months of discharge from institution.	Prescribed by physician and when no in-home support is present for up to 3 months of discharge from institution.
HOMEMAKER			Available when no in-home support is present, for up to 2 months of discharge from institution.
PERSONAL CARE			Available when prescribed by physician for 60 days after discharge from institution.
SKILLED NURSING (RN OR LPN)			Available when prescribed by physician for 60 days after discharge from institution.
SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES	Available when needed.	Available when needed.	Available when needed.
SPECIALIZED PERSONAL CARE FOR FOSTER CARE CHILDREN WITH AIDS	Payment per day does not equate to acuity levels.	Payment per day does not equate to acuity levels.	Payment per day does not equate to acuity levels.
THERAPEUTIC MANAGEMENT OF SUBSTANCE ABUSE	Available when needed. Requires physician order.	Available when needed. Requires physician order.	Available when needed. Requires physician order.
RESTORATIVE MASSAGE		By prescription for specific symptoms noted in handbook.	By prescription for specific symptoms noted in handbook.

APPENDIX J

REQUEST TO TRANSFER TO ANOTHER PAC WAIVER CASE MANAGEMENT AGENCY

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REQUEST TO TRANSFER TO ANOTHER PAC WAIVER CASE MANAGEMENT AGENCY

This is a request to transfer from _____ (current case management agency) to _____ (future case management agency). I understand that to remain in the Project AIDS Care (PAC) program, it is necessary for me to choose another agency that will agree to provide case management services to me.

FREEDOM OF CHOICE:

I have been informed of all the choices for PAC Waiver case management agencies in my area and voluntarily elect to receive case management services from the agency checked below. Please mark the agency of your choice with an "X" in the left column.

CHECK ONE:	NAME OF PAC CASE MANAGEMENT AGENCIES IN AREA:
___	_____
___	_____
___	_____
___	_____
___	_____
___	_____

I understand that if I choose not to transfer to another available case management agency, or if I am unable find an agency willing to provide me with case management services, my eligibility for Project AIDS Care Waiver will terminate and I will be disenrolled from the program.

Print Name of PAC Waiver Recipient: _____

Signature of Recipient: _____ Date: _____

Print Name of Witness: _____

Signature of Witness: _____ Date: _____

_____ Date: _____
Name of Case Management Agency that client is leaving

APPENDIX K

CASE MANAGEMENT AND COMPREHENSIVE NEEDS ASSESSMENT PROTOCOL

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Case Management and Comprehensive Needs Assessment Protocol

The PAC waiver case manager must work with a waiver applicant to verify eligibility for the PAC waiver program. Applicants that request enrollment in the PAC Waiver program must meet the following eligibility criteria:

- Documentation by a physician that the applicant has AIDS;
- Documentation of the presence of AIDS related opportunistic infections;
- Eligible for Medicaid under Supplemental Security Income (SSI), MEDS-AD or the Institutional Care Program (ICP);
- Determined by DOEA/CARES to be at risk of hospitalization or institutionalization in a nursing facility;
- Determined disabled according to Social Security Administration standards;
- Not be enrolled in a Medicaid HMO except one contracted as part of the 1915(b) HIV/AIDS Specialty Waiver;
- Not be enrolled in another Medicaid waiver program;
- Be capable of remaining safely in the home and community;
- Need and receive PAC waiver case management services; and
- Have completed, signed and dated a PAC Waiver Enrollment Application.

Case managers must refer applicants that are not eligible for PAC waiver to other available resources in the community including the Ryan White Care Act program.

Case managers must refer applicants that are not eligible for Medicaid to the local Department of Children and Families to apply for public assistance and Medicaid coverage.

Case managers must send the applicant's completed Physician Referral form and other required documents to the local Department of Elder Affairs, CARES unit, for determining the applicant's risk of hospitalization or nursing home placement Level of Care.

Case managers must explain to the applicant who meets all criteria for enrollment, the program, the applicant's rights and responsibilities, freedom of choice and rights to a fair hearing. The case manager must help the applicant complete an enrollment application with the appropriate dates and signatures. Refer to Chapter 2 - Intake and Completing the PAC Waiver Enrollment Application - in the PAC Waiver Services Coverage and Limitations Handbook.

Case Management and Comprehensive Needs Assessment Protocol

The case manager must coordinate a face-to-face home visit at the recipient's home, along with the nurse care manager from the Disease Management Organization (DMO) to complete an initial Comprehensive Needs Assessment. The home visit must be within five working days from the date of enrollment or the earliest available date. As far as possible, the case manager and the care manager must conduct the home visit at same time to limit any inconvenience to the recipient.

The Comprehensive Needs Assessment is composed of the Social Needs Assessment and the Medical Needs Assessment. The case manager must complete the Social Needs Assessment and the care manager must complete the Medical Needs Assessment. Based on the assessments the care manager in consultation with the case manager will determine the recipient's Acuity Level (Low, Moderate or High). At minimum a Medical Needs Assessment is completed initially at the time of enrollment and annually at the end of the year of enrollment. Refer to Chapter 2 – Comprehensive Needs Assessment - in the PAC Waiver Services Coverage and Limitations Handbook. The case manager and the care manager must work with each other for the benefit and care of the recipient.

Medicaid has a contract with the DMO to manage the care of recipients living with an AIDS diagnosis. A PAC recipient that chooses not to enroll with the DMO must receive an initial assessment or an annual reassessment and an acuity level determination, to remain in the waiver program. Recipients that choose DMO involvement will in addition receive periodic visits and benefit from the DMO program.

The PAC case manager must coordinate all care for the recipient. The case manager must develop a plan of care for delivery of services available under the recipient's acuity level. The case manager must consult with the recipient, caregiver, physician's office and care manager in developing the plan of care. The case manager must coordinate access to services through all funding sources such as services available through organizations in the community, private insurances, Veterans Administration, Medicare (for dually eligible recipients), PAC Waiver and finally the Ryan White Care ACT program.

When the recipient needs a service that is not indicated under an acuity level, or is needed in excess of the maximum limits, the case manager must submit an exception request to the DMO. The DMO must process all exception requests and respond within five working days of receipt of a complete exception request.

The recipient will benefit from the continued communication and cooperation between the recipient, the PAC waiver case manager, the DMO care manager and service providers. They will be able to respond to the changing needs of the recipient, prevent or delay hospitalization, and maintain the recipient in the community as far as it is safely possible.

Jeb Bush
Governor

Alan Levine
Secretary

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