



Florida Medicaid

ASSISTIVE CARE SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration





CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

July 20, 2010

Dear Medicaid Assistive Care Services Provider:

The Assistive Care Services Coverage and Limitations Handbook, July 2009, Section 59G-4.025 is amended to implement changes to the handbook that include:

- Changes in fiscal agent references.
- Updates the reference to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.
- This handbook has been separated from the Assisted Living for the Elderly Waiver Services Program handbook.

Please contact your local Medicaid area office if you have any questions. The Medicaid area offices' phone numbers and addresses are listed on AHCA's Web site at www.ahca.myflorida.com. All of the Medicaid handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

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

Sincerely,

Beth Kidder, Chief
Bureau of Medicaid Services



UPDATE LOG
ASSISTIVE CARE SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material. 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

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web Portal may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE	EFFECTIVE DATE
New Handbook	July 2009

ASSISTIVE CARE SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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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, 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.
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In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose	<p>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.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.</p>
Provider	<p>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.</p>
Recipient	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
General Handbook	<p>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.</p>
Coverage and Limitations Handbook	<p>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.</p>
Reimbursement Handbook	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
Chapter Numbers	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
Page Numbers	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
White Space	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

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. 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. Each update will be designated by an "Update" and the "Effective Date."
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Handbook Updates, continued

How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may consist of one of the following: <ol style="list-style-type: none"> 1. Replacement handbook— Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook—Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.
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Effective Date of New Material

The month and year that the new material is effective will appear in the center of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

Identifying New Information

New material will be indicated by yellow highlighting. 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 and New Information Block

A new label and a new information block will be identified with yellow highlight to the entire section.

New Material in an Existing Information Block

New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence or paragraph affected by the change.

CHAPTER 1

ASSISTIVE CARE SERVICES

PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Florida Medicaid Assistive Care Services Program and specifies the authority regulating assistive care services; the purpose of the program; and the provider qualifications, requirements, and responsibilities.

Legal Authority

The Medicaid Assistive Care Services Program is a state plan Medicaid service program authorized under Section 1902 of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Part 440.167.

The Florida Medicaid Assistive Care Services Program is authorized by Chapter 409; s. 409.906(25), Florida Statutes (F.S.), and rule 59G-4.025, Florida Administrative Code (F.A.C.).

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Description and Purpose

Assistive Care Services Description

The Medicaid Assistive Care Services Program provides care to eligible recipients requiring an integrated set of services on a 24-hour per day basis. Eligible residents must reside in a qualified assisted living facility (ALF), adult family care home (AFCH) or residential treatment facility (RTF) and be provided scheduled and unscheduled care by the facility on a 24-hour per day basis when needed by the recipient.

Assistive Care Service recipients must demonstrate functional limitations that make it medically necessary for them to live in congregate living facilities and have access to integrated assistive care services on a 24-hour per day basis.

The Medicaid Assistive Care Services Program is a Medicaid State Plan program.

Purpose of the Program

The purpose of the Medicaid Assistive Care Service Program is to promote and maintain the health of eligible recipients and to minimize the effects of illness and disabilities in order to delay or prevent institutionalization and allow the individual to continue to reside in the facility.

Purpose of this Handbook

This handbook is intended for use by ALFs, AFCHs and RTFs that provide Assistive Care Services to eligible recipients. It must be used in conjunction with the Florida *Medicaid* Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general.

Note: The handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in rule 59G-5.020, F.A.C. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in rule 59G-4.001, F.A.C.

Description and Purpose, continued

Administrative Responsibility

The Assistive Care Services Program is jointly administered by the Agency for Health Care Administration (AHCA) and the Department of Children and Families (DCF). AHCA is responsible for assuring compliance with federal program requirements, developing Medicaid policy, program operations, and reimbursing Medicaid providers. DCF is responsible for determining the recipients' Medicaid eligibility.

Area Medicaid Offices

There are 11 Medicaid area offices located throughout Florida to assist Medicaid service providers with questions and problems.

Note: See Appendix A of the Florida Medicaid Provider General Handbook for the telephone numbers and addresses of the Medicaid area offices and a listing of the counties that they serve. A map of the Medicaid area offices with phone numbers and addresses is also available on AHCA's website at <http://ahca.myflorida.com>.

Provider Qualifications and Responsibilities

General Assistive Care Service Provider Qualifications

The following types of facilities may enroll as Medicaid Assistive Care Services providers:

- Assisted living facilities (ALFs), licensed pursuant to Chapter 429, F.S;
- Adult family care homes (AFCHs), licensed pursuant to Chapter 429, F.S; and
- Mental health residential treatment (RTFs) facilities, licensed pursuant to Section 394.875 F.S.

Institutions for mental diseases (IMDs) as defined in 42 CFR §435.1009(2) may not enroll as Medicaid Assistive Care Services providers.

Additional Provider Qualifications

ACS providers must be able to provide on-site care to residents seven days a week. The services must be provided by or through the facility billing Medicaid for ACS.

Provider Qualifications and Responsibilities, continued

Assisted Living Facility Administrators Qualifications

Assisted Living Facility (ALF) administrators and managers must meet the requirements of Chapter 429, F.S. and the training requirements of Chapter 58A, Florida Administrative Code (F.A.C.).

Documentation of these qualifications must be maintained in the facility personnel files and must be made available to AHCA monitoring staff or its designees upon request.

Assisted Living Facility Direct Care Staff Qualifications

ALF direct care staff must meet the qualifications for ALF direct care staff and the training requirements of Chapter 58A, F.A.C.

Documentation of these qualifications must be maintained in the staff member's personnel file at the facility and must be made available to AHCA monitoring staff and surveyor staff upon request.

If the administrator delegates the authority to sign ACS service plans to the ALF direct care staff, documentation of the delegation of authority must be maintained by the facility.

Adult Family Care Home Provider, Relief Person and Staff Qualifications

Adult Family Care Home (AFCH) providers, relief persons and staff must meet the requirements of Chapter 429, F.S. and Chapter 58A, F.A.C.

Documentation of these qualifications must be maintained in the facility personnel records and be made available to AHCA monitoring or surveyor staff upon request.

Residential Treatment Facility Manager and Staff Qualifications

All Residential Treatment Facility (RTF) managers and staff must comply with Chapter 394, F.S. and Chapter 65E, F.A.C.

Documentation of these qualifications must be maintained in the facility personnel records and be made available to AHCA monitoring or surveyor staff upon request.

If the administrator delegates the authority to sign ACS service plans to the RTF direct care staff, documentation of the delegation of authority must be maintained by the facility.

**Assistive Care
Provider
Responsibilities**

The assistive care provider has the responsibility to:

1. Assist prospective ACS applicants with applications for Medicaid services, if they have not already been determined eligible for Medicaid.
2. Advise the ACS applicant and recipients of their fair hearing rights and the grievance process.
3. Arrange for a health assessment annually or when significant changes occur in an ACS resident's condition. The assessment must be conducted by a physician or other licensed practitioner of the healing arts defined as a Physician Assistant, Advanced Registered Nurse Practitioner, or Registered Nurse, acting within the scope of their practice under state law.
4. Develop and implement a service plan for each recipient that is available to AHCA monitoring or surveyor staff or its designees upon request.
5. Document, on a daily basis, using the Resident Service Log for Medicaid Assistive Care Services, AHCA-Med Serv Form 037 (Appendix D), July 2009, the amount and type of ACS services that the recipient is receiving from the facility staff on each day for which ACS is billed and ensure that this document is available to AHCA monitoring or surveyor staff or its designees upon request.
6. Maintain up-to-date recipient case records in accordance with the handbook and applicable licensure requirements.
7. Coordinate other services provided to the recipient, such as hospice, waiver, and Medicare (including providing copies of the resident contract and service plan to the staff of the other program in order to coordinate the service plans and avoid service duplication).
8. Provide an integrated set of services on a 24-hour basis.
9. Provide all ACS recipients with a personal needs allowance (PNA) in an amount equal to that set by rule 65A-2.036, F.A.C.
10. Cooperate with the AHCA monitoring or surveyor staff or its designated representatives.
11. Comply with all licensure requirements applicable to the facility.
12. Comply with the requirements of rule division 59G, F.A.C., the Florida Medicaid Provider General Handbook; the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, and the Assistive Care Services Coverage and Limitations Handbook.

Note: See Appendix D for a copy of the Resident Service Log for Medicaid Assistive Care Services, AHCA-Med Serv Form 037, July 2009. The form is available by photocopying it from Appendix D or from the Medicaid's fiscal agent Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Forms. It is incorporated by reference in rule 59G-4.025, F.A.C.

General Enrollment Requirements

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

Enrollment Process

To enroll as an Assistive Care Services provider, the facility must contact the Medicaid area office in the provider's location to make application.

Note: See Appendix C of the Florida Medicaid Provider General Handbook for the telephone numbers and addresses of the Medicaid area offices and a listing of the counties that they serve. A map of the Medicaid area offices with phone numbers and addresses is also available on AHCA's website at <http://ahca.myflorida.com>.

Note: Medicaid enrollment forms may be obtained from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Enrollment. They may also be obtained by calling Provider Enrollment at 800-289-7799 and selecting Option 4. The enrollment forms are incorporated by reference in rule 59G-5.010, F.A.C.

Provider Requirements

General Requirements

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, Assistive Care Services providers are also responsible for complying with the provisions contained in this section.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes health insurance more "portable" so that workers may take their health insurance with them when they moved from one job to another, without losing health coverage. This federal legislation also requires the health care industry to adopt uniform codes and forms to streamline the processing and use of health data and claims. HIPAA also provides protection for the privacy of people's health care information and gives them greater access to that information.

Provider Requirements, continued

**HIPAA
Responsibilities**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as 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. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. 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 Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 866-586-0961 or 800-289-7799, select Option 3.

**Personal Needs
Allowance (PNA)**

All ACS recipients must be allowed to keep from their personal income an amount equal to the Personal Needs Allowance under the Optional State Supplementation (OSS) Program as specified in Chapter 65A, F.A.C. The PNA must be available to the resident by the tenth day of each month. The facility may assist the resident in managing these personal funds, but may not restrict how the resident chooses to spend the PNA funds.

CHAPTER 2

ASSISTIVE CARE SERVICES

COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Assistive Care Services (ACS) Program. It also describes the requirements for service provision, service limitations, and exclusions.

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Service Requirements

Introduction

Medicaid may reimburse for Assistive Care Services provided in qualified assisted living facilities (ALFs), adult family care homes (AFCHs), and residential treatment facilities (RTFs) to eligible Medicaid recipients in accordance with the coverage and limitations in this handbook. This Handbook must be used in conjunction with the Florida Medicaid Provider General Handbook and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

ACS must be rendered by qualified, enrolled providers pursuant to a written service plan that is developed as a result of a detailed assessment of the recipient's condition and service needs. Because services are based on the individual needs of each recipient, not every recipient receives every service.

Note: The handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Service Requirements, continued

**Medicaid
Application
Responsibilities**

Individuals who are not already eligible for Medicaid benefits at the time they need Assistive Care Services must be referred to the local Department of Children and Families (DCF) Automated Community Connection to Economic Self-Sufficiency (ACCESS) office or online at <http://www.myflorida.dcf.state.fl.us/ess> to apply for Medicaid coverage. An authorized representative may submit the application on behalf of the individual.

If the DCF ACCESS office made the original financial eligibility determination, that office will notify the recipient annually of the need to renew eligibility. If the recipient is Medicaid-eligible through Supplemental Security Income (SSI), annual financial redetermination by DCF is not required.

ACS providers are responsible for verifying appropriate Medicaid eligibility prior to the provision of Assistive Care Services.

Note: Information regarding Medicaid eligibility is available on the Internet at <http://www.dcf.state.fl.us/ess/medicaid.shtml>

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for information on methods for verifying recipient eligibility.

**Who Can Receive
Assistive Care
Services**

In addition to being Medicaid eligible, individuals receiving ACS must meet all of the following criteria:

- Be 18 years old or older;
 - Have a health assessment, arranged by the facility, that indicates the medical necessity of Assistive Care Services. The health assessment must be completed by a physician or other licensed practitioner of the healing arts defined as a Physician Assistant, Advanced Registered Nurse Practitioner or Registered Nurse acting within the scope of practice under state law;
 - Be determined to need at least two service components provided under the ACS program based on the health assessment completed by the physician or other licensed practitioner of the healing arts defined as a Physician Assistant, Advanced Registered Nurse Practitioner or Registered Nurse; and, reside in a Medicaid-enrolled ALF, RTF, or AFCH.
-

Service Requirements, continued

Assisted Living for the Elderly Waiver Recipients and Optional State Supplementation Program

Assisted Living for the Elderly (ALE) waiver recipients who receive Optional State Supplementation (OSS) can also receive Assistive Care Services provided the waiver and ACS component services are not duplicative and that the services are listed on the ALE service plans.

The Optional State Supplementation (OSS) Program is administered by the Department of Children and Families. It assists with paying room and board to adult living facilities for indigent elderly or disabled adults.

Note: Information on the Optional State Supplemental Program is available on the Department of Children and Families website at <http://www.dcf.state.fl.us/ess/medicaid.shtml>.

Who Cannot Receive Assistive Care Services

The following individuals may not receive ACS:

- Institutionalized Medicaid recipients residing in institutions such as nursing facilities, state mental hospitals, institutions of mental disease, or intermediate facilities for the developmentally disabled;
- Individuals who participate in any Medicaid managed care program where the capitated payment is designed to cover all Medicaid Services; and
- Recipients who receive services in the ACS facility during the day, but do not reside there.

Functional and Health Criteria

Eligible Medicaid recipients must have, at a minimum, the following functional capabilities:

- Ambulatory, with or without assistance;
- Does not exhibit chronic inappropriate behavior that disrupts the facility's operations or is harmful to self or others;
- Is capable of taking medication with assistance;
- Does not have any stage 3 or 4 pressure sores; and,
- Does not require 24-hour nursing supervision.

Need for Assistive Care Services

A recipient of Assistive Care Services must require an integrated set of services on a 24-hour basis and must have a health assessment by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) acting within the scope of practice under state law establishing the medical necessity of at least two of the four service components described in this chapter under Covered Services and the need for at least one specific Assistive Care Service each day.

Service Requirements, continued

Definition of Medical Necessity

Medically necessary is defined in rule 59G-1.010(166)(a)(c), F.A.C. as follows:

- (a) “Medically necessary” or “medical necessity” means that medical or allied care, goods or services furnished or ordered must meet the following conditions:
- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
 - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
 - Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
 - Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
 - Be furnished in a manner not primarily intended for the convenience of the recipient, the beneficiary’s caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

Covered Services

Assistive Care Services

Assistive Care Services are an array of services provided on a daily basis by or through an enrolled ALF, AFCH, or RTF.

The following components may be included in the Assistive Care Service plan:

- Health support;
- Assistance with activities of daily living (ADLs);
- Assistance with instrumental activities of daily living (IADLs); and
- Assistance with self-administration of medication.

The criteria for provision of each component are explained below.

Covered Services, continued

Health Support Component	Health support is defined as requiring the provider to: Observe the recipient's whereabouts and well-being on a daily basis; Remind the recipient of any important tasks on a daily basis; and, Record and report any significant changes in the recipient's appearance, behavior, or state of health to the recipient's health care provider, designated representative, or case manager.
Assistance with Activities of Daily Living (ADLs) Component	Assistance with activities of daily living (ADLs) is defined as providing individual assistance with one or more of the following activities ambulating, transferring, bathing, dressing, eating, grooming, and toileting. If the health assessment indicates a need for ADL assistance, the ACS provider must provide assistance with at least one ADL daily.
Assistance with Instrumental Activities of Daily Living (IADLs) Component	Assistance with instrumental activities of daily living (IADLs) is defined as providing individual assistance with one or more of the following activities: shopping for personal items, making telephone calls, and managing money.
Assistance with Self-Administration of Medication Component	Assistance with self-administration of medication is defined as assistance with, or supervision of, self-administration of medication at least daily in accordance with licensure requirements applicable to the facility type.
Implementation of Assistive Care Services	Assistive Care Services for an eligible recipient may be provided and billed by the facility from the first day of the need for services as long as the plan of care is being developed and is completed as required.

Assessments for Assistive Care Services

Initial Health Assessment for Assistive Care Services

If the recipient's need and eligibility for ACS begin with the recipient's admission to the ALF or AFCH, the initial assessment requirement is the same as the initial assessment for the facility type.

The initial assessment requirements for ALF residents are in rule 58A-5.0181, Florida Administrative Code (F.A.C.) and for AFCH residents are in rule 58A-14.0061, F.A.C.

If the need and eligibility for ACS begins with admission to the RTF, the initial assessment, completed according to rule 65E-4.016(9), F.A.C., meets the assessment requirement for ACS.

If the need and eligibility for ACS begins after admission to the ALF, AFCH or RTF, the assessment will follow the same procedure used for the re-assessment, as described below, and must be completed prior to billing for ACS.

The assessment, provided by the facility and conducted by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) acting within the scope of his practice, must document the need for **at least two of the four** ACS components.

An assessment completed by a registered nurse for the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program will meet the ACS assessment requirement if a copy is maintained in the resident's file and it documents the need for at least two of the four ACS components.

Along with the assessment requirement, all recipients receiving ACS must have a Certification of Medical Necessity for Medicaid Assistive Care Services, AHCA-Med Serv Form 035, July 2009, signed by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) and the Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036, July 2009, completed and available in the recipient's case file at the facility.

Note: See Appendix B for a copy of the Certification of Medical Necessity for Medicaid Assistive Care Services, AHCA-Med Serv Form 035, July 2009; and see Appendix C for a copy of the Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036. The forms are available by photocopying them from the appendices or from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Forms. They are incorporated by reference in rule 59G-4.025, F.A.C.

Assessments for Assistive Care Services, continued**Annual Assessment for Assistive Care Services**

Recipients receiving Assistive Care Services must have a complete assessment at least annually by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) or sooner if a significant change in the recipient's condition occurs (see below for a definition of a significant change). An annual assessment must be completed no more than one year plus fifteen days after the last assessment. An assessment triggered by a significant change must be completed no more than fifteen days after the significant change.

- The assessment for a resident of a ALF or AFCH must be completed by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) acting within the scope of practice under state law, physician assistant or advanced registered practitioner.
- The assessment for a resident of a RTF must be completed by a physician or licensed mental health professional. The assessment must document the need for at least two of the four ACS components. The assessment for ALF residents must be recorded on the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823.

The assessment for AFCH residents must be recorded on the Resident Health Assessment for Adult Family-Care Homes (AFCH), AHCA Form 3110-1023 (AFCH- 1110) 01/08.

Along with the annual assessment requirement, all recipients receiving ACS must have an updated Certification of Medical Necessity for Medicaid Assistive Care Services, AHCA-Med Serv Form 035, July 2009, signed by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) and the Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036, July 2009, completed and available in the recipient's case file at the facility.

Note: The Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823 and the Resident Health Assessment for Adult Family-Care Homes (AFCH), AHCA Form 3110-1023 (AFCH- 1110) 01/08 are available from the Agency for Health Care Administration, 2727 Mahan Drive, MS 30, Tallahassee, FL 32308. They may also be obtained from AHCA's website at http://ahca.myflorida.com/licensing_cert.shtml. Select Assisted Living Facilities or Adult Family Care Homes. AHCA Form 1823 is incorporated by reference in rule 58A-5.0181, F.A.C., AHCA Form 3110-1023 (AFCH- 1110) is incorporated by reference in rule 58A-14.0061, F.A.C.

Assessments for Assistive Care Services, continued

Significant Change Rule 58A-5.0131, F.A.C., defines significant change as a sudden or major shift in behavior or mood, or deterioration in health status such as unplanned weight change, stroke, heart condition, or stage 2, 3, or 4 pressure sore. Ordinary day-to-day fluctuations in functioning and behavior, a short-term illness such as a cold, or the gradual deterioration in the ability to carry out the activities of daily living that accompanies the aging process are not considered significant changes.

Resident Service Plans for Assistive Care Services

Resident Service Plans Every ACS recipient must have a service plan completed by the ACS service provider. The Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036, July 2009, shall be used for each recipient receiving ACS. The form must be included in the recipient's case file at the facility. The ALF, RTF and AFCH are responsible for ensuring the service plan is developed and implemented.

Note: See Appendix C for a copy of the Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036. The form is available by photocopying it from Appendix C. It is also available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Forms. It is incorporated by reference in rule 59G-4.025, F.A.C.

Service Plan Principles

Service plan development involves six principles:

- ✓ Individuality—addresses individual needs and preferences;
 - ✓ Accountability—specifies who is responsible for providing service;
 - ✓ Outcome orientation—identifies outcome of service;
 - ✓ Completeness—addresses all needs in the health assessment;
 - ✓ Input—resident must be consulted and agree with the plan; and
 - ✓ Staffing—guides staffing and facilities.
-

Resident Service Plans for Assistive Care Services, continued

Required Components of the Service Plan

The Resident Service Plan for Assistive Care Services (AHCA-Med Serv Form 036) must be completed within 15 days after the initial health assessment or annual assessment, be in writing and based on information contained in the health assessment. The service plan must include:

- Identifying information (facility name, resident's name, Medicaid identification number, and date);
- Services that address all needs identified in the health assessment;
- A list of the Assistive Care Services that will be provided on a daily basis;
- Assistance with at least one ADL by the provider if the health assessment indicates a need for ADL assistance;
- Level of functioning and assistance needed;
- Service provider;
- Expected outcome of service;
- A signature and date by facility representative and resident, guardian or designated representative; and
- Updates to the plan when conditions change.

All needed ACS components must be specified in the recipient's Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036.

Note: General Information on how to complete the Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036, is in Appendix C.

Service Plan Approval

Service plan approval requires two signatures:

- For an ALF, the facility administrator or person designated in writing by the administrator must sign.
- For an AFCH, the provider who is the licensee must sign the service plan.
- For a RTF, the administrator or person designated in writing by the administrator must sign.

The service plan must also be signed by the resident except:

- If the resident has a legal guardian, the guardian must sign the form on the resident's behalf.
- If the resident has a representative designated in writing, the representative may sign the form on the resident's behalf. The representative may not be an owner or employee of the facility.

The service plan is considered complete as of the last date signed by either party.

Resident Service Plans for Assistive Care Services, continued

Service Plan Review

The service plan must be reviewed and updated to reflect the current needs of the recipient. The service provider must monitor the service plan for continuity of services and determine if changes in the recipient's status warrant changes in the service plan.

New Service Plan

A new service plan is required on an annual basis or sooner if a significant change in the recipient's condition occurs. The new service plan must be completed no more than 15 days after the annual assessment or an assessment because of a significant change in the recipient's condition.

Service Documentation

The ALF, RTF or AFCH must document that the recipient received services in the facility on each day for which ACS is billed. The service documentation must be made on the Resident Service Log Form for Medicaid Assistive Care Services, AHCA-Med Serv Form 037, July 2009. This form shall be used by the providers to document in the recipient's case file that the daily service was provided.

Note: See Appendix D for a copy of the Resident Service Log, AHCA-Med Serv Form 037, July 2009. The form is available by photocopying it from Appendix D. It is also available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Forms. It is incorporated by reference in rule 59G-4.025, F.A.C.

Assistive Care Services Records

In addition to records required by the applicable licensure standards, ACS records that must be kept include:

- Copies of all eligibility documents;
- Health Assessment Forms, AHCA Form 1823 or AHCA Form 3110-1023 (AFCH-1110) and reassessments forms;
- Certification of Medical Necessity for Medicaid Assistive Care Services, AHCA-Med Serv Form 035;
- The Resident Service Plan for Assistive Care Services, AHCA-Med Serv Form 036, ; and
- The Resident Service Log, AHCA-Med Serv Form 037.

This documentation must be maintained at the facility, kept for at least five years, and be made available to the Agency for Health Care Administration monitoring or surveyor staff or its designated representative, upon request.

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

Resident Service Plans for Assistive Care Services, continued

Assistive Care Services Record Documentation

ACS paper documentation must be legible and written in blue or black ink. No erasures or “whiteout” are permitted. In case of an error, the ALF administrator or designee, AFCH provider or RTF administrator or designee must line through the error, initial and date it, then make the correct entry.

Electronic Records

ACS documentation may be in electronic format. The original, signed (if applicable) documents must be kept in the recipient’s case file in the facility in chronological order for audit, monitoring and quality assurance purposes. If electronic format is used, back up files must be kept.

Service Plan Approval Impasse and Fair Hearing Rights

If the recipient, guardian or representative does not agree with the service plan and resolution cannot be reached, the service provider must provide the recipient with instructions on the fair hearing process and assist the recipient, if requested, with preparation for the fair hearing. If the service provider has any in-house grievance process, the recipient’s rights to a fair hearing cannot be replaced by the in-house grievance process.

Note: More information regarding the fair hearing process may be found at the end of this Chapter.

Leave of Absence and Discharge

Introduction

Medicaid recipients must reside in an ACS-enrolled facility in order to receive ACS services. A recipient that is not a resident of an ACS-enrolled facility will be denied ACS services even if all other eligibility criteria are met. A recipient may be terminated from ACS, under some circumstances, when moving from one facility to another. Recipients must be advised of their rights to appeal these actions when they occur.

Leave of Absence From the Facility

Recipients may leave the facility for more than 24 hours from time to time for health or personal reasons. During such periods, Assistive Care Services are not being provided and may not be billed.

Assistive Care Service Discharge Requirements

If the ALF, AFCH, or RTF representative initiates discharge of an Assistive Care Service recipient, the discharge must be done in accordance with the licensure requirements applicable to the facility type.

Leave of Absence and Discharge, continued

Move to Another Assistive Care Service Provider

If the recipient requests to move or is moved from one ACS-enrolled facility to another ACS-enrolled facility, the discharging facility representative will assist in coordinating the placement, and the recipient will remain eligible to receive Assistive Care Service in the new facility while the new assessment and plan of care are being completed.

The discharging facility may not bill for the day of discharge. The admitting facility may bill for the day of admission.

The receiving facility must obtain a new health assessment, complete the Certification of Medical Necessity for Medicaid Assistive Care Services form (AHCA-Med Serv Form 035) and develop a new service plan on the Resident Service Plan for Assistive Care Services form (AHCA-Med Serv Form 037) for the recipient.

Any time a change in facility is necessary for a recipient who receives Optional State Supplementation (OSS) payments, the change must be coordinated with the recipient's Department of Children and Families case manager.

Move to a Non-Assistive Care Service Provider or to Unlicensed Setting

Changes in residence for a recipient who receives Optional State Supplementation (OSS) payments must be coordinated with the Department of Children and Families (DCF). If it appears that a nursing facility or other placement is necessary, the facility must coordinate with DCF. If the resident participates in the Assisted Living for the Elderly waiver, the local Department of Elder Affairs' (DOEA), Comprehensive Assessment and Review for Long Term Care Services (CARES) unit must also be included in coordinating the plan to seek an appropriate placement.

The discharging facility may not bill Assistive Care Services for the day of discharge.

Reasons for Termination

Termination of Assistive Care Services for any of the following reasons requires a 10-day advance written notice to the recipient:

- Loss of Medicaid eligibility;
- The recipient's condition no longer meets functional criteria;
- The recipient voluntarily moves out of the facility to a non-ACS setting; or
- The recipient transfers to a non-participating ALF, RTF, or AFCH;

In accordance with the Code of Federal Regulations, Title 42, Part 431.213, the notice may be given within 10 days, but no later than the date of termination, if:

- There is factual information confirming the recipient's death, or
 - The facility receives a written statement signed by the recipient that he no longer wishes to receive Assistive Care Services.
-

Appeal Rights and Fair Hearing Process

Right to a Fair Hearing

In accordance with the Code of Federal Regulations, Title 42, Part 431.221(d), a recipient has certain appeal rights. A recipient has the right to appeal any action taken by AHCA, DOEA, DCF or service providers that adversely affects the receipt of services. Advance notice of termination of services initiated by the ALF, RTF, or AFCH must inform the recipient of the right to a fair hearing.

Assistive Care Services recipients must be given ten calendar days advance written notice of change in or termination of services. The advance notice must inform the recipient of the right to a fair hearing.

Where to Apply for a Hearing

Hearing requests must be sent to:

Department of Children & Families
Office of Hearing Appeals
1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, Florida 32399-0700

The telephone number is (850) 488-1429.

How to Request a Hearing

The recipient, or authorized representative, must request a hearing within 90 days of the receipt of the written notification of the adverse decision. The ALF, RTF, or AFCH, if requested, must assist recipients with the fair hearing process.

Continuation of Benefits

If the Assistive Care Services recipient, or authorized representative, requests a fair hearing within ten calendar days of the receipt of the notice of case action or denial of service, Assistive Care Services must continue at the level prior to the adverse action.

If the Assistive Care Services recipient requests a fair hearing and services are reinstated to the prior level, the recipient may be requested to repay that portion of the benefits that the hearing decision determines to be invalid. The recipient must be given written notice of this responsibility by the facility. A copy of the written notice will be placed in the recipient's file at the facility.

Appeal Rights and Fair Hearing Process, continued

Reinstated Benefits

Reinstated or continued benefits must not be reduced or terminated prior to the final hearing decision unless an additional cause for adverse action occurs while the hearing decision is pending, and the recipient fails to request a hearing after a subsequent notice of adverse action.

The ALF, RTF, or AFCH must inform the recipient or authorized representative in writing if benefits are reduced or terminated prior to the hearing decision. A copy of the written notice will be placed in the recipient's file.

Notification of Fair Hearing Decisions

The hearing officer must send the applicant, recipient, or the authorized representative a copy of the Final Order. In addition to describing the final decision of the hearing, the Final Order explains that:

The applicant, recipient, or authorized representative can request a judicial review of the decision; and,
The applicant, recipient, or authorized representative must pay the cost of any judicial review.

Time Limit on Hearing Decision

Federal law requires that the final hearing decision be made and communicated to all involved parties within 90 calendar days of the hearing request.

Necessary Actions to be Taken When Appeal is Granted

Recipient benefit restoration or increases resulting from the final hearing decision must begin within 10 calendar days of the date the local office is notified.

Benefit changes are effective based on the date specified by the hearing officer.

CHAPTER 3

ASSISTIVE CARE SERVICES

PROCEDURE CODES AND FEES

Overview

Introduction

This chapter provides and describes the procedure codes, maximum units of service and approved fees for the Assistive Care Services (ACS) Program.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1

Reimbursement Information

Introduction

For complete reimbursement information, all providers should refer to the Florida Medicaid Provider General Handbook and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. The Florida Medicaid Provider General Handbook is incorporated by reference in rule 59G-5.020, Florida Administrative Code. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500 is incorporated by reference in rule 59G-4.001, Florida Administration Code. These Handbooks are available on the Medicaid fiscal agent's website at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

The Assistive Care Services are paid on a fee-for-service basis. Fee for service is a method of payment where the provider is paid a fee for the procedure that is performed and billed.

Only an enrolled ALF, AFCH or RTF may bill for providing Assistive Care Services. No other entity, including home health agencies, may claim reimbursement for providing ACS. It is the responsibility of the facility, under this program, to furnish ACS to the recipient.

Pay to Provider

Pay to provider is a term used in the Medicaid program to refer to the enrolled Medicaid provider who receives payment from Medicaid for covered services provided to eligible recipients. The pay to provider can be the provider who has provided treatment to a Medicaid recipient or the provider group to which the treating provider belongs.

Reimbursement Information, continued

Procedure Codes

Medicaid reimburses Assistive Care Services based on the Healthcare Common Procedure Coding System (HCPCS) Level II codes.

Level II procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level I codes by beginning with a single letter (A through V) followed by four numeric digits. The codes are part of the standard code set described in HCPCS Level II Expert code book. Please refer to the HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert code book is copyrighted by Ingenix, Inc. All rights reserved.

Services and the Hierarchy of Reimbursement

Assistive Care Services may not be provided if the same services are already provided by another Medicaid program. Medicaid Home Health Services may not be provided or billed if the recipient is receiving Assistive Care Services.

Medicaid Reimbursement Claim Form Information

Effective July 1, 2008, providers must complete and submit CMS-1500 claim forms or the electronic equivalent to receive reimbursement from Medicaid.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for specific procedures for submitting claims for payment. The handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. It is incorporated by reference in rule 59G-4.001, F.A.C.

Fee Schedule

There is one reimbursable procedure code for Assistive Care Services. See Appendix A for the procedure code and per diem rate.

Units of Service

A unit of service equals one day during which the recipient received an Assistive Care Service(s).

Billing for Assistive Care Services for Non-ALE Waiver Recipients

To receive reimbursement, Assistive Care Services providers must check each date the recipient received services. ACS providers are encouraged to bill at the end of each calendar month. Claims for less than one calendar month will be paid as billed. If the period of service encompasses more than one calendar month, separate claims must be submitted for each month in order for the provider to be paid correctly. Assistive Care Service components are reimbursed at a single per diem rate.

Reimbursement Information, continued

Billable Days for Assistive Care Services for Non-ALE Waiver Recipients

Reimbursement will be made only for days that the resident is eligible for and received Assistive Care Services in the facility.

ACS providers cannot bill for those days a resident is not eligible for Medicaid. If a resident was not initially Medicaid-eligible, but applied for and was determined eligible for Medicaid, the provider can bill for services from the effective date of the recipient's Medicaid eligibility.

If the resident's need and eligibility for ACS begins with admission to the facility, reimbursement is made from the day of admission. Reimbursement will not be made for the day of discharge from the facility.

If the recipient is admitted to a hospital or nursing facility from the ACS facility, the last date of service for Assistive Care Services is the day before the recipient was admitted to the other facility.

Note: See Chapter 3 of the Florida Medicaid Provider General Handbook for information on Medicaid recipient eligibility.

Absences of 24 Hours or More

Reimbursement will not be made when the recipient is absent for 24 hours or more. In such cases, reimbursement will be made for the day the resident returns, but not the day the resident leaves. The span of dates of service must be shown on two or more lines on the claim form.

Example: The recipient resides in the ALF where he receives Assistive Care Services beginning on March 1. On March 10, he is admitted to the hospital. He returns to the ALF on March 15, and remains there the rest of the month. The following dates of service are entered on the claim:

03/1/07 – 03/09/07 (9 units of service)

03/15/07—03/31/07 (17 units of service)

Billing for Days the Recipient is Absent

If the facility bills for Assistive Care Services for a day on which the recipient was absent from the facility for 24 hours, any payment made is subject to recoupment.

If another provider, such as a hospital or nursing facility, provides services and bills for that day, the Medicaid area office will contact the ACS provider to require the provider to submit an adjusted claim repaying the funds billed improperly. If the ACS provider does not rectify the problem or repeatedly submits improper claims, the provider will be referred to Medicaid Program Integrity for further action and possible sanction.

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

Reimbursement Information, continued

**Medicaid Payment
is Payment in Full**

ACS providers agree to accept Medicaid payment as payment in full for Assistive Care Services. ACS providers cannot accept or solicit payments from recipients or others for Assistive Care Services. Facilities may accept contributions from recipients and others for the cost of room, board, and for services other than Assistive Care Services.

APPENDIX A
ASSISTIVE CARE SERVICES
FEE SCHEDULE

Code	Description of Service	UNIT	Per Diem Rate
T1020	ACS for Non-ALE Waiver recipients	Daily	\$9.28
T1020 U3	ACS for ALE Waiver recipients	Daily	\$9.28

APPENDIX B
CERTIFICATION OF MEDICAL NECESSITY
FOR
ASSISTIVE CARE SERVICES

The following page contains the Certification of Medical Necessity for Medicaid Assistive Care Services, AHCA-Med Serv Form 035, to be used for all recipients in Assisted Living Facilities, Residential Treatment Facilities (RTF) and Adult Family Care Homes participating in this program. The form will be copied and used by the providers to document, in the recipient's case file, the medical necessity to receive Assistive Care Services.

**CERTIFICATION OF MEDICAL NECESSITY
FOR MEDICAID ASSISTIVE CARE SERVICES**

**Form for Assisted Living Facility, Residential Treatment Facility
and Adult Family Care Home Residents**

Resident Name _____ DOB _____

This is to certify that this recipient is in need of an integrated set of assistive care services on a 24-hour basis, including at least two of the following four service components on a daily basis (check as applicable):

- _____ Assistance with activities of daily living, which is defined as individual assistance with ambulating, transferring, bathing, dressing, eating, grooming, and/or toileting.
- _____ Assistance with instrumental activities of daily living, which is defined as individual assistance with shopping for personal items, making telephone calls, managing money, etc.
- _____ Health support, which is defined as observing the resident's whereabouts and well-being; reminding the resident of any important tasks; and recording and reporting any significant changes in appearance, behavior, or state of health to the health care provider, designated representative, or case manager.
- _____ Assistance with self-administration of medication, which is defined as assistance with or supervision of self-administration of medication as permitted by law.

HEALTH CARE PROVIDER

Facility Name: _____

License Number: _____

Administrators' Signature: _____

Date Signed: _____

CERTIFICATION OF MEDICAL NECESSITY:

Physician/Physician Assistant/
Advanced Registered Nurse Practitioner/
Registered Nurse: _____

APPENDIX C

RESIDENT SERVICE PLAN FOR ASSISTIVE CARE SERVICES

The following pages contain a service plan form that must be used for Assistive Care Services. The form will be copied and used by providers to document the service plan.

General Information

ACTIVITIES

The activities on this form match those listed on the Department of Elder Affairs Health Assessment Instrument, DOEA Form 701B, and the service components on the Certification for Medical Necessity for Assistive Care Services, AHCA-Med Serv Form 035. If the individual does not need any help with an activity, check "Independent."

SERVICE

The level of service to be provided (supervision, assistance, total help, etc.) should match the need shown on the Resident Health Assessment for Adult Family-Care Homes (AFCH), AHCA Form 3110-1023 (AFCH-1110) or the Resident Health Assessment for Assisted Living Facilities (ALF), AHCA Form 1823.

- If the individual is independent in an activity, no other information need be provided for that activity.
- Providing supervision generally means reminding the individual to perform the activity, cueing the individual as to how to do the activity, and monitoring that the individual completes the activity.
- Providing assistance includes the tasks specified below under each activity on a daily basis.
- Providing total help means that the provider performs the entire activity for the resident because the resident is unable to perform any part of the activity for himself/herself.

PROVIDER

Show who will be responsible for providing the service needed. If the provider is other than Facility Staff, specify who will be responsible, for example, a daughter.

EXPECTED OUTCOME

Specify how the resident is expected to function when the proper amount and type of care is provided; the purpose of the service.

OTHER

Specify any other information about the service to be provided.

Activities and Services

AMBULATION

Assistance includes: Providing physical support to enable the resident to move about within or outside the facility. Physical support includes supporting or holding the resident's hand, elbow, or arm; holding on to a support belt worn by the resident to assist in providing stability or direction while the resident ambulates; or pushing the resident's wheelchair. The term does not include assistance with transfer.

Example of an expected outcome for Ambulation: Resident will be able to move about as needed.

BATHING

Assistance includes: Assembling towels, soaps, and other necessary supplies; helping the resident in and out of the bathtub or shower; turning the water on and off; adjusting water temperatures, washing and drying portions of the body which are difficult for the resident to reach; or being available while the resident is bathing.

Example of an expected outcome for Bathing: Resident will be able to maintain body hygiene.

DRESSING

Assistance includes: Helping the resident to choose and to put on and remove clothing.

Example of an expected outcome for Dressing: Resident will be appropriately dressed.

TOILETING

Assistance includes: Assisting the resident to the bathroom, helping to undress, positioning on the commode, and helping with related personal hygiene, including assistance with changing an adult brief. Assistance with toileting includes assistance with routine emptying of a catheter or colostomy bag.

Example of an expected outcome for Toileting: Resident will maintain hygienic body functions.

EATING

Assistance includes: Helping with cutting food, pouring beverages.

Example of an expected outcome for Eating: Resident will be able to consume an adequate and appropriate diet.

GROOMING

Assistance includes: Physically helping the resident with shaving, with oral care, with care of the hair, and with nail care.

Example of an expected outcome for Grooming: Resident's teeth, nails, hair, etc., will be adequately groomed.

TRANSFERRING

Assistance includes: Providing verbal and physical cueing or physical assistance or both while the resident moves between bed and a standing position or between bed and chair or wheelchair.

Example of an expected outcome for Transferring: Resident will be able to move from bed to chair and standing position or wheelchair as needed.

MEDICATIONS

If assistance is required with prescribed medications, the rule requirements for medication assistance applicable to the provider type must be followed.

Non-daily medication supervision is not considered assistance.

Example of an expected outcome for Medications: Resident will take medications as prescribed, and concerns will be communicated to health care provider.

MAKING TELEPHONE CALLS

Assistance includes: Dialing a number for a resident unable to do so.

Example of an expected outcome for Making Telephone Calls: Resident will be able to make telephone calls as needed.

MANAGING MONEY

Assistance includes: Facility staff manages resident's funds as Representative Payee or Power of Attorney. Such assistance will comply with the money management policies specific to each facility.

Example of an expected outcome for managing money: Resident's funds will be spent as desired by the resident.

SHOPPING FOR PERSONAL ITEMS

Assistance includes: Purchasing items the resident chooses.

Example of expected outcome for shopping for personal items: Resident will be able to obtain desired items.

USING AVAILABLE TRANSPORTATION

Assistance includes: Making arrangements for transportation needed by resident and supervising or physically assisting resident into and out of the vehicle.

Escort includes: Providing or arranging for someone to accompany the resident while off-site.

Example of expected outcome for Using Available Transportation: Resident will safely access off-site services and activities.

REMINDING RESIDENT OF IMPORTANT TASKS

Daily tasks could include meals, getting up and going to bed, attending activities, etc.

Example of expected outcome for Reminding Resident of Important Tasks: Resident will know to do specified tasks.

OBSERVING RESIDENT'S APPEARANCE AND WELL-BEING

Daily observation includes observing and interacting with resident each day, noting deviations from the resident's normal state of health and well-being, and contacting the health care provider, case manager, or others as appropriate.

Example of expected outcome for Observing Resident's Appearance and Well-being: Staff will be aware of resident's normal base line and will respond appropriately when deviations occur.

Completion of Service Plan

The service plan must be signed by the provider representative.

- For an ALF, the facility administrator or person designated in writing by the administrator must sign.
- For an AFCH, the provider who is the licensee must sign the service plan.
- For a RTF, the administrator or person designated in writing by the administrator must sign.

The service plan must be signed by the resident except:

- If the resident has a legal guardian, the guardian must sign the form on the resident's behalf.
- If the resident has a representative or designee established pursuant to Section 429.02, Florida Statutes, that person may sign the form on the resident's behalf.

The service plan is considered complete as of the last date signed by either party.

Time Frames

For a new resident, the service plan must be completed no more than 15 days after admission (or the date of the health assessment if after admission).

A new service plan must be completed annually, which means no more than 15 days after the annual health assessment.

A new service plan must be completed no more than 15 days after a health assessment is performed due to a significant change in the condition of the resident.

Significant Change

A sudden or major shift in behavior or mood, or deterioration in health status such as unplanned weight change, stroke, heart condition, or stage 2, 3, or 4 pressure sore. Ordinary day-to-day fluctuations in functioning and behavior, a short-term illness such as a cold, or the gradual deterioration in the ability to carry out the activities of daily living that accompanies the aging process are not considered significant changes.

--Rule 58A-5.0131, Florida Administrative Code

GROOMING	<input type="checkbox"/> Independent	<input type="checkbox"/> Teeth
	<input type="checkbox"/> Provide Supervision	<input type="checkbox"/> Hair
	<input type="checkbox"/> Provide Assistance	<input type="checkbox"/> Nails
	<input type="checkbox"/> Provide Total Help	Other _____

Expected Outcome of Service:

Comments:

TRANSFERRING	<input type="checkbox"/> Independent	<input type="checkbox"/> Provide Total Help
	<input type="checkbox"/> Provide Supervision	
	<input type="checkbox"/> Provide Assistance	

Expected Outcome of Service:

Comments:

ASSISTANCE WITH SELF-ADMINISTERED MEDICATION

ACTIVITY	SERVICE NEED	PROVIDER
MEDICATIONS	<input type="checkbox"/> Independent	<input type="checkbox"/> Facility Non-Nursing Staff
	<input type="checkbox"/> Provide Daily Supervision or Assistance	
	<input type="checkbox"/> Provide Administration	<input type="checkbox"/> Facility Nursing Staff

Expected Outcome of Service:

Comments:

ASSISTANCE WITH INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

ACTIVITY	SERVICE NEED
MAKING A TELEPHONE CALL	<input type="checkbox"/> Independent
	<input type="checkbox"/> Supervision/ Prompting
	<input type="checkbox"/> Dial Number

Expected Outcome of Service:

Comments:

MANAGING MONEY	<input type="checkbox"/> Independent
	<input type="checkbox"/> Provide Assistance
	<input type="checkbox"/> Representative Payee or Power of Attorney

Expected Outcome of Service:

Comments:

SHOPPING FOR PERSONAL ITEMS	<input type="checkbox"/> Independent
	<input type="checkbox"/> Provide Supervision
	<input type="checkbox"/> Provide Total Help

Expected Outcome of Service:

Comments:

USING AVAILABLE TRANSPORTATION	<input type="checkbox"/> Independent <input type="checkbox"/> Provide Supervision <input type="checkbox"/> Provide Assistance or Escort
---------------------------------------	---

Expected Outcome of Service: _____
 Comments: _____

HEALTH SUPPORT

ACTIVITY	<u>SERVICE NEED</u>
-----------------	---------------------

REMINDING RESIDENT OF IMPORTANT TASKS	<input type="checkbox"/> Independent <input type="checkbox"/> Appointments <input type="checkbox"/> Daily Tasks <input type="checkbox"/> Other _____
--	---

Expected Outcome of Service: _____
 Comments: _____

OBSERVING RESIDENT'S APPEARANCE AND WELL-BEING	<input type="checkbox"/> Weekly or Less <input type="checkbox"/> Daily <input type="checkbox"/> Other _____
---	---

Expected Outcome of Service: _____
 Comments: _____

OTHER SERVICES

ACTIVITY	<u>SERVICE NEED</u>
-----------------	---------------------

--	--

Expected Outcome of Service: _____
 Comments: _____

Expected Outcome of Service: _____
 Comments: _____

RESIDENT COMMENTS: _____

Facility Administrator or Designee **DATE** **Resident or Representative** **DATE**

APPENDIX D

ASSISTIVE CARE SERVICES

RESIDENT SERVICE LOG

The following page contains the Resident Service Log for Assistive Care Services. The form will be copied and used by the providers to document, in the recipient's case file, that the daily service was provided.

INSTRUCTIONS

Set Up the Form

- Fill in the name of the provider and the month and year.
- Fill in the resident name and Medicaid number.
- If there are less than 31 days in the month, cross out extra days.

How to Code Your Census

Each day, code who was or was not in the facility on the previous day. For example: On the second day of the month, enter "Y" for residents who were in the facility and "N" for residents who were not in the facility on the first day of the month.

As new residents are admitted during the month, add them to the form and code as appropriate.

Admission and Discharge

You can bill Medicaid for the day the person is admitted to the facility, but you cannot bill Medicaid for the day the person is discharged from the facility.

- Code the day the person was admitted as "Y."
- Code the day the person was discharged as "N."

Temporary Absences

You cannot bill Medicaid for temporary absences of more than 24 hours. Such absences might be for hospitalization, home visits, etc.

- Code the day the person left the facility as "N."
- Code the day the person returned to the facility as "Y."

Completing the Form

At the end of the month, total the number of days (Y) each resident was in the facility and enter in the **Days** column at the right.

Total the number of residents in the facility each day at the bottom.

Add both sets of figures--you should have the same total each way.

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