Notice of Change/Withdrawal

DEPARTMENT OF CHILDREN AND FAMILIES
Agency for Persons with Disabilities
RULE NOS.:RULE TITLES:
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NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 40 No. 235, December 5, 2014 issue of the Florida Administrative Register.

[Substantial rewording of Rule 65G-4.0213. See Florida Administrative Register for present text.]

65G-4.0213 Definitions

For the purposes of this chapter, the term:

(1) Allocation Algorithm: The mathematical formula based upon statistically validated relationships between individual characteristics (variables) and the individual's level of need for services provided through the Waiver as set forth in Rule 65G-4.0214 and as provided in Section 393.0662(1)(a), F.S.

(2) Allocation Algorithm Amount: The result of the Allocation Algorithm apportioned according to available funding.

(3) Amount Implementation Meeting Worksheet (AIM): A form used by the Agency for new waiver enrollees to (a) communicate an individual's Allocation Algorithm Amount, (b) identify proposed services based upon the Allocation Algorithm Amount, and (c) identify additional services, if any, should the individual or their representative feel that any Significant Additional Needs of the individual cannot be met within the Allocation Algorithm Amount. The Amount Implementation Meeting (AIM) Worksheet – APD 2015-01, effective 12-3-2014, is hereby adopted and incorporated by reference in the rule, and may be found on the Agency's website at http://apd.myflorida.com/ibudget/docs/AIM%20Excel%20for%20Rule.pdf,

(4) Approved Cost Plan: The document that lists all waiver services that have been authorized by the agency for the individual, including the anticipated cost of each approved waiver service, the provider of the approved service, and information regarding the provision of the approved service.

(5) Client Advocate: has the same meaning as provided in s. 393.063(6), F.S.

(6) Extraordinary Need: Has the same meaning as provided in s. 393.0662(1)(b), F.S.

(7) Health and Safety: Includes both mental and physical health and safety.

(8) iBudget Amount: total amount of funds that have been approved by the agency, pursuant to the iBudget Rules, for an individual to expend for waiver services during a fiscal year.

(9) iBudget: The home and community-based services Medicaid waiver program under Section 409.906, F.S., that consists of the waiver service delivery system utilizing individual budgets required pursuant to Section 393.0662, F.S. and under which the Agency for Persons with Disabilities operates the Developmental Disabilities Individual Budgeting Waiver.

(10) iBudget Rules: Rules 65G-4.0213 through 65G-4.0218 are the rules which implement and interpret iBudget Amounts.

(11) Individual: a person with a developmental disability, as defined by Section 393.063, F.S., and who is enrolled in iBudget.

(12) Individual representative: The individual's parent (for a minor), guardian, guardian advocate, a designated person holding a power of attorney for decisions regarding health care or public benefits, or a healthcare surrogate. or in the absence of any of the above, a medical proxy as determined under s. 765.401, F.S. The individual's Waiver

Support Coordinator shall ascertain whether an individual has any of these representatives and inform the agency of the identity and contact information.

(13) Individual Review – Agency review of information submitted by a WSC to determine if the request meets significant additional needs criteria.

(14)(a) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. 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;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the individual, the individual's caretaker, or the provider.

(b) 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.

(15) Natural Support: Unpaid supports that are provided voluntarily to the individual in lieu of Waiver services and supports. Any determination of the availability of natural supports includes, but is not limited to consideration of the individual's caregiver(s) age, physical and mental health, travel and work or school schedule, responsibility for other dependents, sleep, and ancillary tasks necessary to the health and well-being of the client.

(16) Questionnaire for Situational Information (QSI) effective 2-15-08: An assessment instrument used by the Agency to determine an individual's needs in the areas of functional, behavioral, and physical status. The QSI is adopted by the Agency as the current valid and reliable assessment instrument and is hereby incorporated by reference. The QSI is available at: http://apd.myflorida.com/waiver/docs/qsi-version-4.pdf.

(17) Service Authorization - An Agency document that authorizes the provision of specific waiver services to an individual and includes, at a minimum, the provider's name and the specific amount, duration, scope, frequency, and intensity of the approved service.

(18) Service Families: Eight categories that group services related to: Life Skills Development, Supplies and Equipment, Personal Supports, Residential Services, Support Coordination, Therapeutic Supports and Wellness, Transportation and Dental Services. The Service Families include the following services:

(a) Life Skills Development, which includes:

1. Life Skills Development Level 1 (formerly known as companion services);

2. Life Skills Development Level 2 (formerly known as supported employment); and

3. Life Skills Development Level 3 (formerly known as adult day training).

(b) Supplies and Equipment which includes:

1. Consumable Medical Supplies;

2. Durable Medical Equipment and Supplies;

3. Environmental Accessibility Adaptations; and

4. Personal Emergency Response Systems (unit and services).

(c) Personal Supports, which includes:

1. Services formerly known as in-home supports, respite, personal care and companion for individuals age 21 or older, living in their own home or family home and also for those at least 18 but under 21 living in their own home; and

2. Respite Care (for individuals under 21 living in their family home).

(d) Residential Services, which includes:

1. Standard Residential Habilitation;

2. Behavior-Focused Residential Habilitation;

3. Intensive-Behavior Residential Habilitation;

4. Live-In Residential Habilitation;

5. Specialized Medical Home Care; and
6. Supported Living Coaching.
(e) Support Coordination, which includes:
1. Limited Support Coordination;
2. Full Support Coordination; and
3. Enhanced Support Coordination.
(f) Therapeutic Supports and Wellness, which includes:
1. Private Duty Nursing;
2. Residential Nursing;
3. Skilled Nursing;
4. Dietician Services;
5. Respiratory Therapy;
6. Speech Therapy;
7. Occupational Therapy;
8. Physical Therapy;
9. Specialized Mental Health Counseling;
10. Behavior Analysis Services; and
11. Behavior Assistant Services.
(g) Transportation; and
(h) Dental Services, which consists of Adult Dental Services.

(19) Significant: Significant means of considerable magnitude or considerable effect.

(20) Significant Additional Needs (SANs): Need for additional funding that if not provided would place the health and safety of the individual, the individual's caregiver, or public in serious jeopardy which are authorized under Section 393.0662(1)(b), F.S., and categorized as extraordinary need, significant need for one time or temporary support or services, or significant increase in the need for services after the beginning of the service plan year. Examples of SAN that may require long-term support include, but are not limited to, any of the following:

a. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

b. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a non-licensed person;

c. A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a diagnosed medical or mental health condition existing simultaneously but independently with another medical or mental health condition in a patient;

d. A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

e. Permanent or long-term loss or incapacity of a caregiver,

f. Loss of services authorized under the state Medicaid plan or through the school system due to a change in age,

g. Significant change in medical, behavioral or functional status

h. Lack of a meaningful day activity needed to foster mental health or prevent regression.

i. One or more of the situations described in Rule 65G-1.047, Crisis Status Criteria

j. Risk of abuse, neglect, exploitation or abandonment.

k. Need for transportation to and from a waiver-funded adult day training program or a waiver-funded supported employment that cannot be accommodated with the funding authorized by the client's support plan without affecting the health and safety of the client, public transportation is not an option due to the unique needs of the client, and no other transportation resources are reasonably available. .

(21) Support plan: An individualized plan of supports and services designed to meet the needs of an individual enrolled in the iBudget. The plan is based on the preferences, interests, talents, attributes and needs of an individual, including the availability of natural supports.

(22) Temporary basis: A time period of less than 12 months.

(23) Waiver: The Developmental Disabilities Individual Budgeting Medicaid Home and Community Based Services Waiver (iBudget) operated by the Agency.

(24) Waiver Support Coordinator (WSC): Means a person who is selected by the individual to assist the individual and family in identifying their capacities, needs, and resources; finding and gaining access to necessary supports and services; coordinating the delivery of supports and services; advocating on behalf of the individual and family; maintaining relevant records; and monitoring and evaluating the delivery of supports and services to determine the extent to which they meet the needs and expectations identified by the individual, family, and others who participated in the development of the support plan.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New_________.

[Substantial rewording of Rule 65G-4.0214. See Florida Administrative Register for present text.]

65G-4.0214 Allocation Algorithm

(1) To establish the Allocation Algorithm Amount for any individual who has not previously had a QSI assessment, a QSI assessment must be completed prior to calculating the Allocation Algorithm Amount under subsection (2).

(a) The QSI assessor should arrange for a face to face meeting with the individual or the individual's representative and the WSC. The WSC shall attend the face to face meeting upon request of the individual or the individual's representative. If the individual or the individual's representative is not capable of fully responding to all of the assessment questions, at least one participant with day-to-day knowledge of the individual's care should participate.

(b) A copy of the completed QSI evaluation and scores shall be provided to the individual and WSC.

(c) Upon receiving QSI results if the individual or their representative identifies as error in the QSI results the WSC shall notify the Agency in writing setting forth the details of the error. At any time, the individual or WSC can prepare a statement to be maintained in individual's Central File identifying any concerns with the QSI assessment score or responses. If any of the challenged responses are considered as variables in determining the individual's algorithm, a corrected assessment may be requested from the agency. The agency shall notify the individual and WSC in writing of any denial of a request for reevaluation, or any reassessment resulting in no change to the challenged score, and give the individual an opportunity to request a fair hearing.

(d) The individual or WSC may request a reassessment any time there has been a significant change in circumstance or condition that would impact any of the questions used as variables in the algorithm determination. The Agency shall arrange for a reassessment within 60 days of the request

(2) To calculate the Allocation Algorithm Amount for each individual, the following weighted values, as applicable, shall be summed, and the resulting total then squared:

(a) The base value for all individuals, 27.57204;

(b) If the individual is age 21 to 30, 47.84726;

(c) If the individual is age 31 or older, 48.96336

(c) If the individual resides in supported or independent living, 35.82201

(d) If the individual resides in a licensed residential facility that is designated to provide Standard or Live-In services, 90.62940

(e) If the individual resides in a licensed residential facility with a Behavior Focus designation, 131.75764

(f) If the individual resides in a licensed residential facility with an Intensive Behavior designation, 209.45584(e) If the individual resides in a licensed residential facility that is a Comprehensive Transitional Education Program or provides Special Medical Home Care, 267.09947

(f) The sum of the scores on the individual questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 0.49540;

(g) If the individual resides in the family home, the sum of the scores on the individual questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 0.63489;

(h) If the individual resides in supported or independent living, the sum of the scores on the individual questions in the QSI Functional Status Subscale (Questions 14-24), multiplied by 2.05291

(i) If the individual resides in supported or independent living, the sum of the scores on the individual questions in the QSI Behavioral Status Subscale (Questions 25-30), multiplied by 1.45011

(j) The individual's score on QSI Question 16, multiplied by 2.49843
(k) The individual's score on QSI Question 18, multiplied by 5.85369;
(l) The individual's score on QSI Question 20, multiplied by 2.67716;
(m) The individual's score on QSI Question 21, multiplied by 2.78776;
(n) The individual's score on QSI Question 23, multiplied by 6.35552;
(o) The individual's score on QSI Question 28, multiplied by 2.28031
(p) The individual's score on QSI Question 33, multiplied by 1.22333
(q) The individual's score on QSI Question 34, multiplied by 2.17640
(r) The individual's score on QSI Question 36, multiplied by 2.67340; and
(s) The individual's score on QSI Question 43, multiplied by 1.93039.

(2) The squared result of the sum of the applicable values of paragraphs (2)(a) through (s) above, is the individual's Allocation Algorithm Amount.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662 FS. History–New__________.

65G-4.0215 General Provisions

(1) Medical necessity alone is not sufficient to authorize a service under the waiver unless:

(a) The individual utilizes all available State Plan Medicaid services, school-based services, private insurance, natural supports, and any other resources which may be available to the individual before expending funds from the individual's iBudget Amount for support or services. As an example, State Plan Medicaid services for children under the age of 21 typically include, personal care assistance, therapies, consumable medical supplies, medical services, and nursing;

(b) No change.

(c) The cost of the services are within the Allocation A~~a~~lgorithm A~~a~~mount unless there is a significant additional need.

(2) No change.

(3) No change.

(a) No change.

(b) When changing the services within the Approved Cost Plan, the individual and his or her WSC shall ensure that sufficient funding remains allocated for unpaid services that were authorized and rendered prior to the effective date of the ~~this~~ change.

(c) Individuals enrolled in iBudget will have flexibility and choice to budget or adjust funding among the following ~~some~~ services without requiring additional authorizations from the Agency, provided the individual's overall ~~individuals~~ iBudget Amount is not exceeded and all health and safety needs are met:

1, Life Skills Development 1
2. Life Skills Development 2
3. Life Skills Development 3 at the 1 to 10 ratio.
4. Durable Medical Equipment;
5. Adult Dental.
6. Personal Emergency Response Systems
7. Environmental accessibility adaptations,
8. Consumable Medical Supplies,
9 Transportation.
10. Personal Supports if below $16,000
11. Respite if below $5,000

Medically necessary services will be authorized by the Agency for covered services not listed above if the cost of such services are within the individual's iBudget Amount. The Agency will authorize services in accordance with criteria identified in Section 393.0662(1)(b), F.S., medical necessity requirements of Section 409.906, F.S., subsection 59G-1.010(166), F.A.C., and handbook limitations adopted in Rule 59G-13.083, F.A.C., unless said handbook is superseded and replaced by a subsequently adopted handbook specifically entitled the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, ~~referencing the replacement of this handbook~~, and the requirements of 42 CFR 440.230(d).

(d) Service authorization and any modifications to it must be received by the provider prior to service delivery. This includes changes to the authorization as a result of individuals redistributing funds within their existing cost plan. Service authorizations will not be approved retroactively. In limited circumstances, an exception may be made on a case by case basis by the Agency regional office to correct an administrative error or to consider a health and safety risk and emergency situations. ~~Retroactive application of changes to service authorizations is prohibited without written approval from the agency.~~

(4) No change.

(5) (a) iBudget Waiver providers must have applied through the Agency for Persons with Disabilities to ensure that they meet the minimum qualifications to provide iBudget Waiver services. iBudget Waiver providers must also be enrolled as a Medicaid provider though the Agency or Healthcare Administration. To enroll as a provider for iBudget Waiver Services, the provider must first submit an application to the Agency or Persons with Disabilities using the Regional iBudget Provider Enrollment Application – Waiver Support Coordinator (WSC) – APD 2015-02, effective date 7-1-2015, for waiver support coordinator applications, or the Regional iBudget Provider Enrollment Application – Non-WSC – APD 2015-03, effective date 7-1-2015, for all other provider applications. These forms are hereby incorporated by reference and are available at http://apdcares.org/providers/enrollment/. The Agency for Persons with Disabilities will review the application, requesting missing documentation, and issue a decision about whether the provider meets the qualifications to provide services. The qualifications to provide services are identified in the handbook adopted in Rule 59G-13.083, F.A.C., unless said handbook is superseded and replaced by a subsequently adopted handbook specifically entitled the Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook.

(b) If a waiver provider wishes to expand from solo to agency enrollment status, provide additional services, or expand services geographically, the provider must notify the Agency regional office serving the geographic area in which expansion is requested by submitting an Provider Expansion Request form –APD 2015-04, effective date 8-20-2013, which is hereby incorporated by reference and is available at http://apdcares.org/providers/enrollment/. The Agency regional office must approve any expansion prior to the provision of expanded services. Before the Agency regional office approves a provider for expansion, the Agency regional office must determine that the provider has:

1. An 85% or higher on their last Quality Assurance Organization (QIO) report. If a provider does not have a history of a QIO review, this does not prevent consideration for expansion;

2. No identified alerts (i.e., background screening, medication administration, and validation);

3. No outstanding billing discrepancies or plan of remediation;

4. No adverse performance history in their home region; and

5. No open investigations or referrals to AHCA and DCF.

Agency staff shall check with the provider's home regional office to determine whether there is a history of complaints filed and logged on the remediation tracker, any open investigations or referrals to AHCA's Medicaid Program Integrity (MPI) or the Attorney General's Medicaid Fraud Control Unit (MFCU), or the Department of Children & Families (DCF). The Agency regional office shall conduct the determination required under this paragraph in not more than 30 days.

(6) (a) When a individual is enrolled in the iBudget, that individual remains enrolled in the waiver position allocated unless the individual becomes disenrolled due to one of the following conditions:

1. The individual or individual's representative chooses to terminate participation in the waiver.

2. The individual moves out-of-state.

3. The individual loses eligibility for Medicaid benefits and this loss is expected to extend for a lengthy period.

4. The individual no longer needs waiver services.

5. The individual no longer meets level of care for admission to an ICF/IID.

6. The individual no longer resides in a community-based setting (but moves to a correctional facility, detention facility, defendant program, or nursing home or resides in a setting not otherwise permissalbe under waiver requirements.

7. The individual is no longer able to be maintained safely in the community.

8. The individual becomes enrolled in another home and community-based services (HCBS) Waiver.

If an individual is disenrolled from the waiver and becomes eligible for reenrollment within 365 days that individual can return to the waiver and resume receiving waiver services. If waiver eligibility cannot be re-established or if the individual who has chosen to disenroll has exceeded this time period, the individual cannot return to the waiver until a new waiver vacancy occurs and funding is available. In this instance, the individual is added to the waitlist of individuals requesting waiver participation. The new effective date is the date eligibility is re-established or the individual requests re-enrollment for waiver participation.

(b) Providers are responsible for notifying the individual's WSC and the Agency if the provider becomes aware that one of these conditions exists. If a individual, family member, or individual representative refuses to cooperate with the provision of waiver services (such as refusing to develop a cost plan or support plan, participation in a required QSI assessment or other approved agency needs assessment tool, or refuses to annually sign the waiver eligibility worksheet, required to establish a level of care) the Agency will review the circumstances on a case by case basis to determine if the individual can be removed from the waiver, as the waiver requires these specific documents for continued waiver eligibility. Individuals are exempted from this provision if they do not have the ability to give informed consent and do not have a guardian or individual representative. The Agency shall not remove an individual from the waiver due to non-compliance if it directly impacts the individual's health, safety, and welfare.

*Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New*_________.

65G-4.0216 Establishment of iBudget Amount

(1) The iBudget Amount for an individual shall be the Allocation Algorithm A~~a~~mount, as provided in Rule 65G-4.0214, plus any approved Significant Additional Needs funding as provided in 65G-4.0218 ~~pursuant to Section 393.0662(1)(b), F.S~~.

(2) No change.

(3) Significant Additional Needs Review: For new waiver enrollees the Allocation Algorithm A~~a~~mount is calculated and provided to the individual and the individual's WSC. The WSC will discuss the Allocation Algorithm A~~a~~mount with the individual, or individual's representative and, if applicable, the client advocate, in order to determine if the individual has any Significant Additional Needs. The Agency will conduct an Individual Review to determine whether services requested meet health and safety needs and waiver coverage and limitations. In the event a WSC does not submit a request for SANs and the individual, the individual's representative or the client advocate disagrees with the WSC's failure to submit a SAN funding request, the WSC shall submit in writing its reasons for not requesting SANs funding to the Agency, the individual, the individual's representative and the client advocate. The individual, the individual's representative or the client advocate may submit in writing to the Agency the reasons for their disagreement. ~~representative in order to determine if the individual has any Significant Additional Needs.~~ The Agency may approve an increase to the iBudget Amount if additional funding is required to meet the Significant Additional Needs. For new enrollees the AIM Worksheet form APD 2015-01 will be completed as part of the I~~i~~ndividual R~~r~~eview.

(4) through (6) No change.

*Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New*_________.

65G-4.0217 iBudget Cost Plan

(1) When an individual's iBudget Amount is determined, the WSC must submit a cost plan proposal that reflects the specific waiver services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the provider of those services and supports, including natural supports.

(2)~~(1)~~ Each individual's proposed iBudget cost plan shall be reviewed and approved by the Agency in conformance with the iBudget Rules and the Florida Medicaid Developmental Disabilities Waiver Services Coverage and Limitations Handbook, November 2010, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-01050, as adopted by Rule 59G-13.083, F.A.C. (5-133-2012), which is hereby incorporated by reference. Any conflict between the handbook and these iBudget Rules shall be resolved in favor of these Rules.

(2) through (3) renumbered (3) through (4) No change.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New__________.

65G-4.0218 Significant Additional Need Funding

(1) Supplemental funding for Significant Additional Needs (SAN) may be of a one-time, temporary, or long-term in nature including the loss of Medicaid State Plan or school system services due to a change in age. A WSC shall submit any requests for SAN funding on behalf of an individual. SAN funding requests must be based on at least one of the three categories, as follows:

(a) through (c) No change.

(2) through (3) No change.

(4) ~~To ensure that limited SAN funding is targeted to those individuals most in need whenever an individual requests SAN funding, a proposed cost plan~~ For any SAN request, the WSC shall submit a cost plan proposal that reflects the specific waiver services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the provider of those services and supports, including natural supports. The request should also include an explanation of why additional funding is needed, and any additional documentation appropriate to support the request. If there are any concerns about the accuracy of the QSI results the WSC shall submit this information as well. The cost plan proposal shall be submitted indicating how the current budget allocation and requested SAN funds would be used. Documentation of attempts to locate natural or community supports, third-party payers, or other sources of support to meet the individual's health and safety needs must also be submitted.

(5) If an individual's iBudget includes Significant Additional Needs beyond what was determined by the Allocation Algorithm, and the Agency determines that the service intensity, frequency or duration is no longer medically necessary, the Agency will adjust the individual's services to match the current need ~~ensure health and safety~~.

(6) The Agency will request the documentation and information necessary to evaluate individuals' increased funding requests based on the individual's needs and circumstances. The documentation will vary according to the funding request and may include the following as applicable: support plans, results from the Questionnaire for Situational Information, cost plans, expenditure history, current living situation, interviews with the individual and his or her providers and caregivers, prescriptions, data regarding the results of previous therapies and interventions, assessments, and provider documentation. Paragraphs (a) through (c) set forth examples of the types of documentation the Agency utilizes in reviewing SAN funding requests in specific circumstances.

(a) For an extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved:

1. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention:

a. Psychological assessments/Psychiatric reports

b. Baker Act admission and discharge summaries for last 12 months

c. Behavior assessments, plans and data for last 12 months

d. If school-aged, current IEP, school behavior plan and data

e. If under 21 – a description of behavior services accessed or attempted through the Medicaid State Plan

f. Incident Reports, policy reports within the last 12 months

g. Behavior Summary Report from the Area Behavior Analyst

2. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a non-licensed person:

a. Supporting documentation from physician, or others that document the medically necessary situation.

b. Prescription by a physician, ARNP or physician assistant

c. List of specific duties to be performed

d. Nursing care plan (if applicable)

e. Documentation from Skilled Nursing Exception Process (if applicable)

3. A chronic comorbid condition.

a. The term comorbid condition means a medical condition existing simultaneously but independently with another medical condition in a patient

b. Supporting documentation from physician, or others that document the medically necessary situation.

4. A need for total physical assistance with activities such as eating, bathing, toileting, grooming and personal hygiene.

a. Updated QSI

b. Documentation from caregivers

(b) For a significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase is approved. A significant need includes, but is not limited to:

1. The provision of environmental modifications:

a. Documentation of approval from landlord, if home is rented

b. Documentation of ownership of the home by the client or their family

c. The appropriate number of bids per the Handbook

d. Home Accessibility Assessment if over $3500

e. Documentation of how environmental modifications would ameliorate the need

2. Durable Medical Equipment:

a. Prescription and recommendation by a licensed physician, ARNP, physician assistant, PT or OT

b. Documentation that durable medical equipment used by the client has reached the end of its useful life or is damaged, or the client's functional or physical status has changed enough to require the use of waiver-funded DME that has not previously been used.

c. Three bids for items costing $1,000 and over

3. Services to address the temporary loss of support from a caregiver:

a. Description of why caregiver can no longer provide care

b. Age and medical diagnoses of caregivers

c. Documentation from doctor(s) regarding caregiver(s) ability to provide care.

4. Special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. Temporary means a period of fewer than 12 continuous months.

(c) A significant increase in the need for services after the beginning of the service plan year that would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy because of substantial changes in the client's circumstances, including, but not limited to:

1. Permanent or long-term loss or incapacity of a caregiver: Same criteria as (b)3 above.

2. Loss of services authorized under the state Medicaid plan due to a change in age:

a. Medicaid Prior Service Authorization

b. Documentation that other caregivers are not available

3. A significant change in medical or functional status which requires the provision of additional services on a permanent or long-term basis that cannot be accommodated within the client's current iBudget. As used in this subparagraph, the term "long-term" means a period of 12 or more continuous months.

(7) No change.

(8) No additional funding for an individual's services shall be provided if the need for the additional funding is not premised upon a need that arises after the implementation of the initial iBudget Amount, or ~~new need, but~~ is created by the individual's failure to ensure that funding remained sufficient to cover services previously authorized in accordance with subsections 65G-4.0215(2) and (3)~~(6)~~, F.A.C.

(9) No change.

Rulemaking Authority 393.501(1), 393.0662 FS. Law Implemented 393.0662, 409.906 FS. History–New________.