Notice of Instruction

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West Central Florida Area Agency on Aging, Inc.

aaa

Assistance. Advocacy. Answers on Aging.

Notice of Instruction Number: #032411 – Updated 3008 Requirements - lc

TO: All Lead Agencies

FROM: Lauren Cury, Medicaid Waiver Specialist (Extension 5613)

DATE: March 24, 2011

SUBJECT: Updated AHCA MEDSERVE-3008 Form for Medicaid Waiver Recipients

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The purpose of this Notice of Instruction is to provide WCFAAA's Lead Agencies with the updated 3008 Form and is to be implemented for use with Medicaid Waiver program recipients effective immediately.

The AHCA MEDSERVE-3008 Form dated May 2009, replaces the previous CF Med 3008 Form dated July 2006. During the transition to the new form, the CARES Unit will continue to accept the previous CF Med 3008 Form for level of care determinations; however, it is expected that case managers will begin using the updated form for all new enrollments immediately.

Please note: Case managers are expected to ensure that important physician contact information, including the physician's name and telephone number, are documented in Section J of the AHCA MEDSERVE-3008 Form. The CARES Unit will not be able to accept incomplete forms.

The AHCA MEDSERVE-3008 Form is located for your convenience at the following link: http:elderaffairs.state.fl.us/english/cares_3008ppp.php

WCFAAA appreciates your immediate attention and cooperation in regards to this directive. Thank you for your continued commitment to Florida's elders. Should you require additional program information, please contact your WCFAAA Medicaid Waiver Specialist.

Attachments:
AHCA MEDSERVE-3008 Form
AHCA MEDSERVE-3008 Instructions
AHCA MEDSERVE-3008 Physician Letter

FLORIDA MEDICAID

MEDICAL CERTIFICATION FOR NURSING FACILITY/HOME- AND COMMUNITY-BASED SERVICES FORM
(Replaces Patient Transfer and Continuity of Care Form)

(A) FACILITY INFORMATION

Facility From _____ **Admission Date** _____/_____/_____ **Discharge Date** _____/_____/_____

Facility To _____

(B) DEMOGRAPHIC INFORMATION

Individual's DOB _____/_____/_____ Sex _____ Race _____

Individual's Last Name First Name Initial

Individual's Address Phone Number

Nearest Relative/Health Care Surrogate Phone Number

PHYSICIAN INFORMATION

Name _____

Will you care for individual in NF? ☐ Yes ☐ No

If no, referred to _____

Principal Diagnosis _____

Secondary Diagnosis _____

Discharge Diagnosis _____

(Problem List may be attached)

Surgery Performed & Date _____/_____/_____

Allergy/Drug Sensitivity _____

MEDICATION AND TREATMENT ORDERS (copies may be attached)

(C) PREADMISSION SCREENING FOR MENTAL ILLNESS/MENTAL RETARDATION

(Complete for admission to NF only)

1. Is dementia the primary diagnosis? ☐ Yes ☐ No
2. Is there an indication of, or diagnosis of mental retardation (MR), or has the individual received MR services within the last 2 years? ☐ Yes ☐ No
3. Is there an indication of, or diagnosis of serious mental illness (MI), such as (check all that apply)
   - ☐ Schizophrenia
   - ☐ Mood disorder
   - ☐ Somatoform disorder
   - ☐ Paranoia
   - ☐ Panic or severe anxiety disorder
   - ☐ Personality disorder
   - ☐ Other psychotic or mental disorder leading to chronic disability
4. Has the individual received MI services within the past two years? ☐ Yes ☐ No
5. Is the individual a danger to self or others? *(please attach explanation)* ☐ Yes ☐ No
6. Is the individual on any medication for the treatment of a serious mental illness or psychiatric diagnosis? ☐ Yes ☐ No
7. If yes, is the MI or psychiatric diagnosis controlled with medication? ☐ Yes ☐ No
8. Is the individual being admitted from a hospital after receiving acute inpatient care? ☐ Yes ☐ No
9. Does the individual require nursing facility services for the condition for which he/she received care in the hospital? ☐ Yes ☐ No
10. Has the physician certified the individual is likely to require less than 30 days of nursing facility services? ☐ Yes ☐ No

(D) ADDITIONAL ORDERS (Orders may be attached)

(E) HISTORY & PHYSICAL AND LABS

1. PHYSICAL EXAM (History & Physical may be attached)

Head Ears Eyes Nose & Throat (HEENT) _____

Neck _____

Cardiopulmonary _____

Abdomen _____

GU _____

Rectal _____

Extremities _____

Neurological _____

Other _____

Free from communicable diseases ☐ Yes ☐ No

2. LABORATORY FINDINGS (Reports may be attached)

TB Test ☐ Yes ☐ No Date _____/_____/_____

Results _____

Chest X-Ray ☐ Yes ☐ No Date _____/_____/_____

Results _____

(F) IMMUNIZATIONS GIVEN

- ☐ Pneumococcal Vaccine Date _____/_____/_____
- ☐ Influenza Vaccine Date _____/_____/_____
- ☐ Tetanus and Diphtheria Vaccine Date _____/_____/_____
- ☐ Herpes Zoster Vaccine Date _____/_____/_____

(G) PHYSICAL THERAPY (Attach Orders)

☐ New Referral ☐ Continuation of Therapy

FREQUENCY OF THERAPY _____

INSTRUCTIONS _____

- ☐ Stretching
- ☐ Passive Range of Motion (ROM)
- ☐ Active assistive
- ☐ Active
- ☐ Progressive resistive
- ☐ Coordinating Activities
- ☐ Non-weight bearing
- ☐ Partial weight bearing
- ☐ Full weight bearing
- ☐ Progress bed to wheelchair
- ☐ Recovery to full function
- ☐ Wheelchair independent
- ☐ Complete ambulation

Sensation Impaired: ☐ Yes ☐ No

Restrict Activity: ☐ Yes ☐ No

PRECAUTIONS

- ☐ Cardiac
- ☐ Other _____

ADDITIONAL THERAPIES (Attach Orders)

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Respiratory Therapy
- ☐ Other _____

(H) TREATMENT AND EQUIPMENT NEEDS (Attach Orders)

- ☐ Catheter Care
- ☐ Changing Feeding Tube
- ☐ Dressing Changes
- ☐ Ostomy Care
- ☐ Wound Care
- ☐ Suctioning
- ☐ Trach Care
- ☐ Diabetic Care
- ☐ Monitor Blood Sugar/Frequency _____
- ☐ Administer Insulin
- ☐ Tube Feeding
- ☐ Oxygen *(Select from below)*
  - ☐ PRN
  - ☐ Continuous @L/min _____

Instructions

(I) SPECIAL DIET ORDERS (Orders may be attached)

(J) TYPE OF CARE RECOMMENDED *(MUST BE COMPLETED AND SIGNED)*

Check one

Rehab Potential (check one) ☐ Good ☐ Fair ☐ Poor

☐ Skilled Nursing Extended Care Facility (ECF), Duration _____

☐ Intermediate Care: Duration _____

Admission Date to Nursing Facility _____/_____/_____

I certify that this individual requires ECF Nursing Facility Care for the condition for which he/she received care during hospitalization.

☐ I certify that this individual is in need of Medicaid Waiver Services in lieu of Institutional placement.

Print Physician's Name _____

Address _____

Phone Number _____ **Fax** _____

Email Contact Address _____

Effective Date of Medical Condition _____/_____/_____

_____/_____/_____

Physician's Signature and Date Required

FOR ONLINE APPLICANT USE ONLY

IF APPLYING FOR MEDICAID, PLEASE INCLUDE DCF ACCESS CONFIRMATION NUMBER BELOW:

AHCA MEDSERV-3008 form, May 2009--(Replaces Patient Transfer and Continuity of Care Form 3008 July 2006 - CF Med 3008)

FLORIDA MEDICAID

NURSING/SOCIAL WORK ASSESSMENT
[Page 2 may be completed by a Nurse or Social Worker]

INDIVIDUAL'S NAME _____ **DOB** _____

ADLs ARE AT TIME OF NF ADMISSION

(K) VISION (w/glasses if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Blind	**AMBULATION**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Total help ☐ 6. Bed bound
HEARING (w/aid if used)	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Deaf	**ENDURANCE**	☐ 1. Tolerates distance (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short acitivities ☐ 4. No tolerance
SPEECH	☐ 1. Good ☐ 2. Fair ☐ 3. Poor ☐ 4. Gestures or signs ☐ 5. Unable to speak	**TRANSFER**	☐ 1. No assistance ☐ 2. With assistive device ☐ 3. With supervision ☐ 4. Requires assistance* ☐ 5. Bed bound
COMMUNI-CATION	☐ 1. Transmits messages/receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**WHEELCHAIR USE**	☐ 1. No assistance ☐ 2. Assistance with difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable ☐ N/A
MENTAL AND BEHAVIOR STATUS	☐ 1. Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Aggressive ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Wanders ☐ 9. Safety restraints needed ☐ 10. Well motivated	**TOILETING**	☐ 1. No assistance ☐ 2. With assistive devices ☐ 3. With supervision ☐ 4. Requires assistance ☐ 5. Total assistance ☐ A- Bathroom ☐ B - Bedside commode ☐ C- Bedpan
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fatigue ☐ 3. Irritations (rash) ☐ 4. Open Wound ☐ 5. Decubitus Site:_____ Stage:_____ Size:_____	**BLADDER CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence - once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Catheter - indwelling
DRESSING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Has to be dressed	**BOWEL CONTROL**	☐ 1. Continent ☐ 2. Occasional incontinence-once/week or less ☐ 3. Frequent incontinence - up to once a day ☐ 4. Total incontinence ☐ 5. Ostomy
BATHING	☐ 1. No assistance ☐ 2. Supervision ☐ 3. Requires assistance* ☐ 4. Is bathed ☐ A- Tub ☐ B - Shower ☐ C- Sponge Bath	**FEEDING**	☐ 1. No assistance ☐ 2. Tray set up only ☐ 3. Requires assistance ☐ 4. Is fed ☐ 5. Aspirates
TEACHING NEEDS	☐ 1. Diabetic ☐ 2. Cardiac ☐ 3. Ostomy ☐ 4. Other (specify):	**DIET**	☐ 1. Full ☐ 2. Mechanical Soft ☐ 3. Pureed ☐ 4. Other (specify):

***(HANDS ON NEEDED)**

Comments:_____

SIGNATURE AND TITLE_____ **DATE**_____/_____/_____

(L) SOCIAL WORK ASSESSMENT

Prior Living Arrangement_____

Long Range Plan/Agency Referrals_____

Adjustments to Illness or Disability_____

Comments _____

Instructions for Completing the AHCA MedServ-3008 Form

This form is a dual-purpose form for physicians to certify Nursing Facility Care or Home- and Community-Based Services (Medicaid Waiver Services)

I. In an effort to assist you in the completion of the AHCA MedServ-3008 form, the following definitions are being provided.

A. **Skilled Nursing (ECF):** ECF means extended care facility. The definition of skilled nursing is found in the Florida Administrative Code, and can be found in 59G-4.290(b). [To access this information on the Internet use the following link: https://www.flrules.org/gateway/readFile.asp?sid=0&tid=1849225&type=1&file=59G-4.290.doc]

Skilled Nursing must be:

- Ordered by and remain under the supervision of a physician;
- Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse;
- Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
- Required on a daily basis;
- Reasonable and necessary to the treatment of a specific documented illness or injury; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage.

B. **Intermediate Care:** The definition of intermediate care is also found in the Florida Administrative Code, and can be found in 59G-4.180(3)(b). [To access this information on the Internet use the following link: https://www.flrules.org/gateway/readFile.asp?sid=0&tid=1847673&type=1&file=59g-4.180.doc]

Intermediate Care must be:

- Ordered by and remain under the supervision of a physician;
- Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals;
- Required to be performed under the supervision of licensed nursing or other health professionals;
- Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient;
- Required on a daily or intermittent basis;
- Reasonable and necessary to the treatment of a specific documented medical disorder, disease or impairment; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage

II. To further assist you in the completion of the AHCA MedServ-3008 form, the following **instructions** are provided: (Additional information is located on the Comprehensive Assessment and Review for Long Term Care Services (CARES) Web site: http://elderaffairs.state.fl.us/english/cares.php

Section A: **Facility Information**

List where the individual is transferring to and from, along with admission and discharge dates, if appropriate.

Section B: Demographic Information

- Enter individual's demographic information
- List physician's name
- Answer the question regarding the care of the individual in the nursing facility and who the individual will be referred to if you will not be caring for individual
- List the principal diagnosis for which the individual has been hospitalized/admitted
- List all other diagnosis for which the individual has for secondary diagnosis, as well as discharge diagnosis
- Attach Problem List
- Include any surgeries performed, including date of surgery
- List all allergies and drug sensitivities
- If the individual is to be discharged with medication(s) and/or treatment(s), specify them by name, including dosage and method of administration. If you need additional space, you may attach additional pages, but please indicate that you have done so.

Section C: Preadmission Screening

This section contains items numbered one through ten, which meet the mental illness/mental retardation screening required by Omnibus Budget Reconciliation Act (OBRA) '87. Answer each item by checking the appropriate box for Yes or No to indicate the individual's mental illness/mental retardation (MI/MR) status (additional documentation may be attached).

Section D: Additional Orders (Orders may be attached)

Section E: History & Physical and Labs

1. **Physical Exam: (History & Physical may be attached)**

- Review all body systems of the individual and list specific findings
- Briefly describe the individual's medical history
- Describe the individual's mental and physical functional limitations
- Use additional order space (D) for additional findings if needed

2. **Laboratory Findings: (Reports may be attached)**

- Check if TB Test has been completed or not; provide date of testing and results
- List date of chest x-ray and results
- Use additional order space (D) for other lab orders or results

Section F: Immunizations Given

- List dates of last Pneumococcal vaccine, Influenza vaccine, Tetanus and Diphtheria vaccine and Herpes Zoster vaccine.

Section G: Physical Therapy (Attach Orders)

- Check if this is a new referral or continuation of therapy
- List frequency of treatment
- Provide instructions for other physical therapy needs (Use additional order (D) if needed)
- Check therapy ordered and precautions if any for individual

Section G: Additional Therapies (Attach Orders)

- List type of therapy ordered and precautions if any for the individual
- Use additional order space (D) for additional therapies not listed
- List instructions for therapy identified

Section H: Treatment and Equipment Needs (Attach Orders)

- Check type of treatment and equipment needs for individual
- Use additional order space (D) for other treatment or equipment needs not listed

Section I: Special Diet Orders (Orders may be attached)

- List individual's dietary restrictions and requirements

Section J: Type of Care Recommended

- Indicate the type of care (skilled nursing ECF or intermediate) recommended for the individual and the duration
- Indicate the individual's rehabilitation potential (good, fair, or poor)
- List admission date to nursing facility
- Indicate certification of individual requiring ECF Nursing Facility Care for the condition for which the individual received care during hospitalization
- Indicate certification of individual in need of Medicaid Waiver Service in lieu of institutional care placement
- List effective date for certification
- Print name, address, and phone number of physician
- MD/DO must sign and date form as mandated by federal law

Section K: The Nursing/Social Work Assessment Form

- Activities of Daily Living (ADLs) are at the time of admission into the nursing facility
- (*) Indicates "Hands on is needed" for this ADL
- Check appropriate box on the Nursing Assessment to indicate the level of assessment of the individual at time of admission
- Add additional nursing assessment information in the Comment Section
- Sign and date form

Section L: The Nursing/Social Work Assessment Form

- Social Work Assessment is to be completed at the time of nursing facility admission
- Sign and date form

The Nursing/Social Work Assessment Form (page 2 of the AHCA MedServ-3008 form) is to be completed for individuals in hospitals and nursing facilities seeking level of care for nursing facility placement.

- Page 2 is not required for individuals in the community seeking nursing facility placement
- Page 2 may be completed and signed by a nurse or social worker

Please note: This form is also located for your convenience at the following link: http://elderaffairs.state.fl.us/english/cares.php

From this link you may download the form, complete as appropriate for each individual, save the .pdf file as needed before printing, signing and returning to CARES.

DEPARTMENT OF ELDER AFFAIRS
STATE OF FLORIDA

RICK SCOTT
GOVERNOR

CHARLES T. CORLEY
INTERIM SECRETARY

Date: _____

_____ _____
Patient's Name
_____
_____
_____

Dear Dr.

The above-named patient has applied for **nursing home placement** or to receive **home- and community-based services** to assist him/her to remain in the community.

Your response will enable us to determine if your patient meets the established criteria for enrollment. Some examples of home- and community-based services include assistance with bathing, shopping, homemaking, home- delivered meals, emergency alert response, medication management, incontinence supplies and case management. Our goal is to prevent or delay nursing home placement by supporting elders and their caregivers with the services they need and help them enjoy a better quality of life while remaining in their communities.

The federal government requires that the Medical Certification for Nursing Facility/Home- and Community-Based Services Form, AHCA MedServ-3008, be signed by a licensed Medical Doctor or Doctor of Osteopathy. This **certifies** an individual's need for Medicaid-funded nursing facility placement or home- and community-based services. The properly completed AHCA MedServ-3008 form contains all of the federal criteria for the medical documentation that is required to establish Level of Care (LOC) and determine Medicaid eligibility required by Chapter 42, Code of Federal Regulations (42CFR) and the Nursing Home Reform Act.

All fields on page 1 of the AHCA MedServ-3008 Form must be addressed. If additional medical documentation is attached, it must address any and all items left blank on the form. The Nursing/Social Work Assessment Form (page 2 of the AHCA MedServ-3008 Form) is to be completed for individuals in hospitals and nursing facilities seeking Level of Care for nursing facility placement. Page 2 is not required for clients in the community seeking nursing facility placement. Page 2 may be completed and signed by a nurse or social worker.

In an effort to assist you in the completion of AHCA MedServ-3008 form, the following definitions are provided:

Skilled Nursing must be:

- Ordered by and remain under the supervision of a physician;
- Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse;
- Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
- Required on a daily basis;
- Reasonable and necessary to the treatment of a specific documented illness or injury; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage.

Intermediate Care must be:

- Ordered by and remain under the supervision of a physician;
- Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals;
- Required to be performed under the supervision of licensed nursing or other health professionals;
- Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient;
- Required on a daily or intermittent basis;
- Reasonable and necessary to the treatment of a specific documented medical disorder, disease or impairment; and
- Consistent with the nature and severity of the individual's condition or the disease state or stage.

Section C: Contains items numbered one through ten, which meet the mental illness/mental retardation screening required by the Nursing Home Reform Act and Pre-Admission Screen and Resident Review Process (PASRR). Answer each item by checking the appropriate box as Yes or No to indicate the patient's mental illness/mental retardation status. Additional PASRR information may be accessed at http://elderaffairs.state.fl.us/english/cares_pasrr.php.

Section J: The effective date should reflect the date on which the patient's current medical condition became effective. The signature date is the date on which the physician actually signs page 1 of the AHCA MedServ-3008 form.

We appreciate your taking the time to complete this form to help your patient. Please return the completed AHCA MedServ-3008 form to the following address:

_____

_____

_____

Sincerely,

Please note: This form is also located for your convenience at the following link: http://elderaffairs.state.fl.us/english/cares_3008ppp.php

From this link you may download the form, complete as appropriate for each individual, save the .pdf file as needed before printing, signing and returning to CARES.