# Sec. 10.09.32.04. Covered Services

*Latest version.*

The Program covers the following services when they have been documented as medically necessary:

A. HIV Diagnostic Evaluation Services.

(1) These services shall include, as a unit of service, performance of a bio-psychosocial assessment and development or revision of a recommended plan of care, as well as all other necessary covered services described in §A(2) of this regulation.

(2) A bio-psychosocial assessment shall be completed within 6 weeks of the participant s referral for case management services. The assessment shall be performed by the HIV diagnostic evaluation services provider representative on the multidisciplinary team and include:

(a) A review of relevant medical and other records, with the participant s or legal representative s written consent;

(b) A consult with the participant s attending physician and current providers of medical, social, or other support services, as appropriate;

(c) A face-to-face assessment of the participant, preferably at the participant s residence, to determine:

(i) Medical, psychiatric, and substance abuse history, including current medications;

(ii) Nutritional status;

(iii) Emotional and behavioral status;

(iv) Health care coverage;

(v) Living situation;

(vi) Personal support systems;

(vii) Employment and income status;

(viii) Health education;

(ix) Social support; and

(x) Any additional service needs;

(d) A consult, as appropriate, with the participant or the participant s legally authorized representative or representatives; and

(e) All areas listed on the Department s approved sample bio-psychosocial assessment form.

(3) Documentation of the results of the assessment shall be kept in the participant s record.

(4) The multidisciplinary team will develop a written, individualized plan of care which reflects both the needed and available services being recommended for delivery.

(5) The plan of care shall:

(a) Be participant-centered and goal-oriented;

(b) Be developed and written in collaboration with the participant and other members of the multidisciplinary team;

(c) Incorporate findings from the bio-psychosocial assessment;

(d) Incorporate findings and recommendations from the multidisciplinary team;

(e) Establish a plan for after-hours crises, including medical and social crises, and other emergency situations;

(f) Document the proposed frequency of contact with a minimum of 1 face-to-face meeting every 6 months; and

(g) Address all areas listed on the Department s approved sample plan of care form.

B. HIV Ongoing Case Management Services.

(1) The case manager shall assist with the bio-psychosocial assessment and with development or revision of the plan of care by:

(a) Conducting a face-to-face assessment of the participant s psychosocial status and health care needs and briefing the multidisciplinary team on the findings;

(b) Participating in the development or revision of an individualized plan of care for the participant;

(c) Encouraging the participant s and representative s participation in the multidisciplinary team process; and

(d) Linking the participant with any services needed on an emergency basis before the plan of care or revision is finalized.

(2) The HIV ongoing case management provider may be reimbursed for the case manager s participation as a member of the multidisciplinary team, convened to review the participant s case by the HIV diagnostic evaluation services provider.

(3) The case manager:

(a) Participates as a member of the multidisciplinary team convened by the HIV diagnostic evaluation services provider;

(b) Assumes responsibility for providing case management services to the participant;

(c) Acts as a point of contact for the case; and

(d) Implements and monitors the plan of care recommended by the HIV diagnostic evaluation services provider s multidisciplinary team and approved by the participant.

(4) HIV ongoing case management services shall be provided to participants who:

(a) Are recommended in the plan of care as needing case management; and

(b) Who elect to receive case management services.

(5) The plan of care shall be implemented as follows:

(a) The case manager shall make initial contact with the participant to assure that medical and support referrals were completed and followed-up on;

(b) The case manager shall maintain regular contact that will occur at intervals agreed on by the participant and case manager in the plan of care;

(c) The case manager or HIV ongoing case management provider, when necessary, shall respond to participant-initiated non-emergency contact within 2 working days;

(d) The participant or the participant s representative or representatives shall be offered a copy of the plan of care;

(e) The case manager shall document every direct and indirect contact, including assessing the progress of implementation of the plan of care in the participant s record;

(f) The case manager shall assist the participant with each action plan to reach the goals outlined in the plan of care;

(g) The case manager shall advise the participant about available services and service providers, by making referrals to and arrangements with service providers selected by the participant, and by assisting the participant in gaining access to services for which the participant is eligible and which the participant chooses, to include:

(i) The full range of Medical Assistance services; and

(ii) Other available support services such as medical, social, housing, financial, and counseling;

(h) The case manager shall provide the participant with any necessary counseling concerning:

(i) Government entitlement programs;

(ii) Health programs;

(iii) Social programs;

(iv) Educational programs;

(v) Psychological programs;

(vi) Financial programs;

(vii) Housing programs; and

(viii) Other resources;

(i) The case manager shall follow up with referral sources; and

(j) The case manager shall examine the actual service delivery against the plan of care.

(6) The case manager shall monitor and evaluate the participant s plan of care as follows:

(a) Review and check the status of each activity outlined in the plan of care;

(b) Modify the action plan or goals to accommodate the participant s changing needs or changes in service availability;

(c) Monitor the plan of care at regular intervals that have been predetermined at the time of the plan of care or more often depending on participant need;

(d) Evaluate the plan of care, in collaboration with the participant, at least every 6 months, with input from any members of a multidisciplinary team who have been involved with the participant s care.

(7) The case manager shall document the following in the participant s record regarding case closure:

(a) Participant notification, including date of closure, reason, and explanation of closure;

(b) Participant s notification of right to re-enter services at a later time;

(c) Documentation of coordination and referral to a new provider if desired by the participant; and

(d) Documentation of a participant s non-response to case manager attempts to reach the participant over a 6-month period of time with at least 3 attempts to contact the participant.