



COMMUNITY CHOICES WAIVER PROVIDER MANUAL

Chapter Seven of the Medicaid Services Manual

Issued July 1, 2013

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

The Community Choices Waiver is a Medicaid Home and Community-Based Services Waiver providing alternative services to individuals which assists them to live in the community instead of a nursing facility or institution.

This provider manual chapter specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of federal and state laws and Department of Health and Hospitals (DHH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. Should a conflict exist between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This manual chapter is intended to give providers of Community Choices Waiver services information necessary to fulfill their vendor contract with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and department rules.

Oversight of the services offered through the Community Choices Waiver is conducted through licensure compliance and program monitoring. The DHH Bureau of Health Services Financing (BHSF) and the DHH Office of Aging and Adult Services (OAAS) are responsible for assuring provider compliance with these regulations.

Waiver services to be provided are specified in the Plan of Care which is written by the support coordinator, based on input from the planning team, and then forwarded to the OAAS or its designee for approval. The planning team is comprised of the recipient, the support coordinator, and in accordance with the recipient's preferences, members of the family/natural support system, appropriate professionals and others whom the recipient chooses. The Plan of Care contains all services and activities involving the recipient, non-waiver as well as waiver services. Recipients are to receive those waiver services included in the Plan of Care and approved by the appropriate support coordination designee or OAAS regional office (as applicable). Notification of approved services is forwarded to the provider by the support coordinator, and the contracted data management agency issues prior authorization to the providers based on the approved Plan of Care.

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the Centers for Medicare

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and Medicaid Services.

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COVERED SERVICES

This section provides information about the services that are covered in the Community Choices Waiver (CCW) program. For the purpose of this policy, when reference is made to “individual” or “recipient”, this includes that person’s responsible representative, legal guardian(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

NOTE: Recipients who are approved for CCW cannot receive Long-Term - Personal Care Services (LT-PCS).

Support Coordination

Support coordination, also referred to as case management, is a mandatory service designed to assist recipients in gaining access to necessary waiver and other State Plan services, as well as needed medical, social, educational, housing and other services, regardless of the funding source for these services. The core elements of support coordination include the following:

- Intake;
- Assessment;
- Plan of care development and revision;
- Linkage to direct services and other resources;
- Coordination of multiple services among multiple providers;
- Monitoring/follow-up;
- Reassessment;
- Evaluation and re-evaluation of level of care and need for waiver services;
- Ongoing assessment and mitigation of health, behavioral and personal safety risk;
- Responding to recipient crisis;
- Critical incident management; and
- Transition/discharge and closure.

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Support coordination agencies shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by recipients in receiving direct services.

Support coordination agencies shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen their agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The Office of Aging and Adult Services (OAAS) must be immediately notified of the circumstances surrounding a refusal to provide/continue to provide services. This requirement can only be waived by OAAS.

Support coordination agencies must establish and maintain effective communication and good working relationships with recipients' service providers.

Recipients must be given information and assistance in directing and managing their services. When recipients choose to self-direct their personal assistance services (PAS), support coordinators are to inform recipients about their responsibilities as an employer and compliance with all applicable state and federal laws, rules, policies, and procedures.

Support coordinators shall be available to recipients for on-going support and assistance in these decision-making areas regarding employer responsibilities. (See Appendix B for information on accessing the "*OAAS Community Choices Waiver Self-Direction Employer Handbook*".)

Standards

Support coordination agencies must be:

- Certified by the Louisiana Department of Health (LDH) to operate a support coordination agency;
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation;
- Sign a performance agreement with OAAS;
- Assure staff attends all training mandated by OAAS;
- Enroll as a Medicaid provider of support coordination services in all of the regions in which it intends to provide services;

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- Comply with all LDH and OAAS policies and procedures; and
- Be listed on the Support Coordination Agency Freedom of Choice (FOC) form.

Reimbursement

Support coordination is reimbursed at an established monthly rate. The data contractor issues a monthly authorization to the support coordination agency. After the support coordination requirements are met and documented in the case management database, the authorization is released to the support coordination agency. For each quarter in the recipient's plan of care (POC) year, if the support coordination agency does not meet all of the requirements for documentation in the case management database the prior authorization (PA) for the last month of that quarter will not be released until all requirements are met. A unit of service is one month.

Transition Intensive Support Coordination (TISC)

TISC is a service that assists individuals who are currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and other Medicaid State Plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services.

Support coordinators shall comply with all the requirements described above under the "Support Coordination" Section. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient's approved POC. (See Appendix F for a complete list of the CCW services available during the transition process.)

Standards

Support coordination agencies that provide TISC must be:

- Certified by LDH to operate a support coordination agency;
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation;
- Sign a performance agreement with OAAS;
- Assure staff attends all training mandated by OAAS;
- Enroll as a Medicaid provider of support coordination services in all regions in

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- which it intends to provide services;
- Comply with all LDH and OAAS policies and procedures; and
- Be listed on the Support Coordination Agency FOC form.

Service Exclusions

Support coordination agencies are not allowed to bill for TISC until after the individual has been approved for the CCW.

The scope of TISC shall not overlap with the scope of support coordination; therefore, duplicate billing is not allowed.

Service Limitations

Support coordination agencies may be reimbursed up to six months from the POC approval date. Reimbursement is contingent upon the support coordinator performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the support coordinator. Support coordination agencies will not receive reimbursement for any month during which no activity was performed and documented in the transition process.

Reimbursement

TISC is reimbursed at a monthly rate as set by Medicaid for a maximum of six months from the POC approval date prior to the date of transition. Payment will not be authorized until the data contractor receives an approved POC indicating that the individual was/is a nursing facility resident during the time period in which prior authorization is requested.

Transition Services

Transition services assist an individual, who has been approved for a CCW opportunity, to leave a nursing facility and return to live in the community.

Transition services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for a CCW opportunity and are transitioning from a nursing facility to their own living arrangement in a private residence where the individual is directly responsible for his/her own living expenses. Transition services may also be used to purchase essential items needed for the individual even when the individual is residing with others. Allowable expenses are those necessary to enable the individual to establish a basic household, excluding expenses for room and board. These services must be identified and approved in the individual's POC in accordance with LDH and OAAS policies and procedures.

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Transition services include the following:

- Security deposits that are required to obtain a lease on an apartment or house;
- Specific set-up fees or deposits for:
 - Telephone;
 - Electricity;
 - Gas;
 - Water; and
 - Other such necessary housing start-up fees or deposits.
- Essential furnishings to establish basic living arrangements:
 - Living Room – sofa/love seat, chair, coffee table, end table and recliner;
 - Dining Room – dining table and chairs;
 - Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers; nightstand, comforter, sheets, pillows, lamp and telephone;
 - Kitchen – refrigerator, stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, dishcloths, towels and potholders;
 - Bathroom – towels, hamper, shower curtain and bath mat;
 - Miscellaneous - window coverings, window blinds, curtain rod, washer, dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron and ironing board; and
 - Moving Expenses – moving company and cleaners (prior to move, onetime expense).
- Health and welfare assurances:
 - Pest control/eradication;
 - Fire extinguisher;
 - Smoke detector; and
 - First aid supplies/kit.

NOTE: Support coordinators must exhaust all other resources to obtain these items prior to utilizing the waiver.

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Standards

Support coordination agencies that provide transition services must be:

- Certified by LDH to operate a support coordination agency;
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation;
- Sign a performance agreement with OAAS;
- Assure staff attends all training mandated by OAAS;
- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services;
- Comply with all LDH and OAAS policies and procedures; and
- Be listed on the Support Coordination Agency FOC form.

Service Exclusions

Transition services do not include the following:

- Monthly rental payments;
- Mortgage payments;
- Food;
- Monthly utility charges; and
- Household appliances and/or items intended solely for diversional/recreational purposes (e.g., television, stereo, computer, etc.).

These services do not constitute room and board. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

Service Limitations

There is a \$1,500 lifetime maximum limit per individual. Services must be prior approved by the

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OAAS Regional Office or its designee and require PA.

NOTE: This is the only waiver service that is not subject to the individual's annual POC maximum cost.

When the individual transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the individual.

The purchaser for these items may be the recipient, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, the support coordination agency is the only source that can bill for these services.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office, or its designee, gives final POC approval upon receipt of the "Decision Notice" form from the Medicaid office.

When the final approval is issued, the data contractor is notified to set up a transition service expense tracking record in the database for the recipient and to release the authorization. The support coordination agency is notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

The OAAS Regional Office or its designee shall maintain documentation, including each individual's "OAAS Transition Services Form (TSF)" with original receipts and copies of canceled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes. (See Appendix B for information about this form.)

Billing for transition services must be completed within 60 calendar days after the individual's actual move date in order for the reimbursement to be paid.

NOTE: If the individual is not approved for CCW services and/or does not transition, but transition service items were purchased, the OAAS Regional Office must notify the OAAS state office to allow for possible reimbursement.

If it is determined that additional items are needed after the TSF was approved, and there are remaining transition funds in the individual's budget, the support coordinator must submit another TSF within 90 calendar days after the individual's actual move date. The same procedure outlined above shall be followed for any additional needs.

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Environmental Accessibility Adaptations

Environmental accessibility adaptations (EAA) are those necessary physical adaptations made to the home to reasonably assure the health and welfare of the recipient, or enable the recipient to function with greater independence in the home. Without these necessary adaptations, the recipient would require institutionalization.

NOTE: Necessity is determined when all options (e.g., durable medical equipment, assistive technology, etc.) have been explored and exhausted, or found to be ineffective for justifiable reasons.

There must be an identified need for an environmental accessibility adaptation as indicated by the interRAI Home Care Assessment.

All costs associated with the EAA service (e.g., initial home evaluation also referred to as the Basic Assessment, final inspection, costs of durable medical equipment (DME), costs of construction, etc.) are subject to the participant's annual budget allotment.

If the recipient does not own the home, written permission from the landlord must be obtained prior to proceeding with EAAs which require structural modification(s).

All proposed EAAs documented in the home evaluation report must be reviewed by the OAAS Regional Office before proceeding.

Upon completion of any structural modification(s), the EAA assessor or OAAS must ensure that all specifications have been satisfactorily met before payment shall be made to the provider that completed the work.

NOTE: If OAAS or the EAA assessor determines that the work of the EAA provider is substandard, the EAA provider who completed the work shall be responsible for the costs associated with bringing the work up to standard, including but not limited to materials, labor and costs of any subsequent inspections. If the substandard work is the result of the EAA assessor's home evaluation report, the EAA assessor shall be responsible for the associated costs indicated above.

The adaptation(s) must be accepted, fully delivered, installed and operational in the current POC year that it was approved, unless otherwise approved by OAAS or its designee.

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Environmental accessibility adaptations include the following:

- Ramps:
 - Portable; and
 - Fixed;
- Lifts:
 - Porch;
 - Stair;
 - Hydraulic;
 - Manual; and
 - Electronic;
- Modifications of bathroom facilities:
 - Roll shower;
 - Sink;
 - Bathtub;
 - Toilet; and
 - Plumbing;
- Additions to bathroom facilities:
 - Roll shower;
 - Water faucet controls;
 - Floor urinal;
 - Bidet; and
 - Turnaround space;
- Specialized accessibility/safety adaptations/additions:
 - Door widening;
 - Electrical wiring;
 - Grab bars;
 - Handrails;
 - Automatic door opener/doorbell;
 - Voice activated, light activated, motion activated and electronic devices;
 - Fire safety adaptations;

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- Medically necessary air filtering device*;
- Medically necessary heating/cooling adaptations*; and
- Other modifications to the home necessary for medical or personal safety.

***A doctor's statement concerning medical necessity for air filtering devices and heating/cooling adaptations is required. The support coordinator must obtain such documentation prior to requesting approval from the OAAS Regional Office, or its designee, and must maintain the documentation in the recipient's records.**

Standards

All EAA assessors and providers must meet the requirements outlined in Section 7.6 – *Provider Requirements* of this manual chapter.

All modifications, adaptations, additions or repairs must be made in accordance with all of the local and state housing and building codes, and must meet the Americans with Disabilities Act requirements.

Environmental accessibility adaptations shall be authorized only if the recipient's health and welfare can be reasonably assured for the duration of the POC year within their remaining resource allocation.

Service Exclusions

This service is not intended to cover basic construction costs. For example, in a new home, a bathroom is already part of the building costs and waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

The following adaptations are not included in this service:

- General house repairs;
- Flooring (carpet, wood, vinyl, tile, stone, marble, etc.);
- Interior/exterior walls not directly affected by an adaptation;
- Lighting or light fixtures that are for non-medical use;
- Furniture;
- Vehicle adaptations;

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- Roofing, initial or repairs. This also includes covered ramps, walkways, parking areas, etc.;
- Exterior fences or repairs made to any such structure;
- Motion detector or alarm systems for security, fire, etc.;
- Fire sprinklers, extinguishers, hoses, etc.;
- Smoke, fire and carbon monoxide detectors;
- Interior/exterior non-portable oxygen sites;
- Replacement of toilets, septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring or fixtures when not affected by an adaptation, not part of the installation process or not one of the pieces of medical equipment being installed;
- Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.);
- Any service covered by the Medicaid State Plan; or
- Any equipment or supply covered by Medicaid's DME program.

NOTE: Some lifts, filters, etc., may be covered as a DME item. The support coordinator must first explore the possibility of these items being covered through the DME program by assisting the recipient in making a PA request with a DME provider.

Service Limitations

Services must be reviewed by the OAAS Regional Office or its designee and be prior authorized.

It is strictly prohibited for the EAA provider to charge the recipient an amount in excess of the prior approved amount for completion of the job.

Reimbursement

Environmental accessibility adaptation services shall be billed for the amount authorized. The EAA assessor must approve the completion of the modification prior to the provider submitting billing. If for some reason the EAA assessor is unable to perform this function, the OAAS Regional Office must provide approval prior to the provider submitting billing.

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Personal Assistance Services

Personal assistance services (PAS) include assistance and/or supervision necessary for the recipient with functional impairments to remain safely in the community. PAS includes the following services and supports based on the approved POC:

- Supervision or assistance in performing activities of daily living (ADLs);
- Supervision or assistance in performing instrumental activities of daily living (IADLs);
- Protective supervision solely to assure the health and welfare of the recipient;
- Supervision or assistance with health-related tasks;
- Supervision or assistance while escorting/accompanying the recipient outside the home to perform tasks, including IADLs, health maintenance or other needs as identified in the POC and to provide the same supervision or assistance as would be provided in the home; and
- Extension of therapy services, defined as:
 - Assistance in reinforcing instruction and aids in the rehabilitative process by an attendant who has been instructed by a licensed therapist on the proper way to assist the recipient in follow-up therapy sessions; and
 - Performance of basic interventions by an attendant who has been instructed by a registered nurse on how to increase and optimize functional abilities in performing ADLs such as range of motion exercise.

Transportation is not a required component of PAS although providers may choose to furnish transportation for recipients during the course of providing PAS. If transportation is furnished, the provider must accept all liability for their employee transporting a recipient. It is the responsibility of the provider to ensure that the employee has a current, valid driver's license and automobile liability insurance.

PAS is provided in the recipient's home or can be provided in another location outside of the recipient's home if the provision of these services allows the individual to participate in normal life activities pertaining to the ADLs and IADLs cited in the POC. IADLs may not be performed in the recipient's home when the recipient is absent from the home. There shall be no

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duplication of services. PAS may not be provided while the recipient is attending or admitted to a program or setting which provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided. In cases where a recipient goes to the Emergency Room, the PAS worker may provide assistance up until the time the recipient is admitted to the hospital.

The provision of PAS services outside of the recipient's home does not include trips outside of the borders of the state without prior, written approval by OAAS or its designee, through the POC or otherwise. The recipient's written request must include a detailed explanation sent to OAAS, or its designee, at least 24 hours prior to the anticipated travel, when applicable.

The PAS allotment may be used flexibly in accordance with the recipient's preferences and personal schedule and OAAS's documentation requirements when the following guidelines are met.

- The approved allocation must be used in accordance with the recipient's preferences within a single, specific prior authorization period.
- Unused portions of the prior authorized allocation may not be saved or borrowed from one prior authorized period to another.
- Total hours used may not exceed the prior authorized period amount.
- Variations from the approved POC in accordance with the recipient's preference must be documented by the direct service/support worker (DSW) on the designated service log. (See Section 7.7 – *Record Keeping* of this manual chapter)
- The **need** for paid support/assistance with particular tasks/services, without assignment of specific time per task, must be documented in the approved POC.

Supervision or Assistance with ADLs

Recipients may receive supervision or assistance in performing the following ADLs for their continued well-being and health:

- Eating:
 - Verbally reminding the recipient to eat;
 - Cutting food into bite-size pieces;
 - Assisting the recipient with feeding; and/or

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- Assisting the recipient with adaptive feeding devices (not to include tube feeding unless the DSW has received the required training pursuant to R.S. 37:1031-1034);
- Bathing:
 - Verbally reminding the recipient to bathe;
 - Preparing the recipient's bath;
 - Assisting the recipient with dressing and undressing; or
 - Assisting the recipient with prosthetic devices;
- Dressing:
 - Verbally reminding the recipient to dress;
 - Assisting the recipient with dressing and undressing; or
 - Assisting the recipient with prosthetic devices;
- Grooming:
 - Verbally reminding the recipient to groom;
 - Assisting the recipient with shaving, applying make-up, body lotion or cream;
 - Brushing or combing the recipient's hair;
 - Brushing the recipient's teeth; or
 - Other grooming activities;
- Transferring:
 - Assisting the recipient with moving body weight from one surface to another, such as moving from a bed to a chair; or
 - Assisting the recipient with moving from a wheelchair to a standing position;
- Ambulation:
 - Assisting the recipient with walking (regardless of assistive device); or
 - Assisting the recipient with wheelchair use; and

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- Toileting:
 - Verbally reminding the recipient to toilet;
 - Assisting the recipient with bladder and/or bowel requirements, including bedpan routines and changing incontinence pads or adult briefs, if required; or
 - Draining/emptying a catheter or ostomy bag is allowed, but this is not to include removing or changing bags or tubing, inserting, removing and sterilizing irrigation of catheters.

Supervision or Assistance with IADLs

Recipients may receive supervision or assistance in performing routine household tasks that may not require performance on a daily basis, but are essential for sustaining their health and welfare. **The purpose of providing assistance or support with these tasks is to meet the needs of the recipient, not the housekeeping needs of the recipient's household.** Assistance or support with IADLs includes the following:

- Light housekeeping;
 - Vacuuming and mopping floors;
 - Cleaning the bathroom and kitchen;
 - Making the recipient's bed; or
 - Ensuring pathways are free from obstructions;
- Food preparation and food storage as required specifically for the recipient;
- Shopping (with or without the recipient) for items specifically for the recipient such as:
 - Groceries;
 - Personal hygiene items;
 - Medications; or
 - Other personal items;
- Laundry of the recipient's clothing and bedding;

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- Medication reminders with self-administered prescription and non-prescription medication that is limited to:
 - Verbal reminders;
 - Assistance with opening the bottle or bubble pack;
 - Reading the directions from the label;
 - Checking the dosage according to the label directions; or
 - Assistance with ordering medication from the drug store.

NOTE: Assistance does NOT include taking medication from the bottle to set up pill organizers, administering medications and applying dressing that involves prescription medication and aseptic techniques of skin problems, unless the DSW has received the required training pursuant to R.S. 37:1031-1034.

- Assistance with scheduling (making contacts and coordinating) medical appointments including, but not limited to appointments with:
 - Physicians;
 - Physical therapists;
 - Occupational therapists; and
 - Speech therapists;
- Assistance in arranging medical transportation depending on the needs and preferences of the recipient with:
 - Medicaid emergency medical transportation;
 - Medicaid non-emergency medical transportation;
 - Public transportation; and
 - Private transportation; and
- Accompany the recipient to medical appointments and provide assistance throughout the appointment.

Protective Supervision

Protective supervision may be provided to assure the health, welfare and maintenance of a recipient who has cognitive or memory impairment or who has physical weakness as defined by the OAAS comprehensive assessment.

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Supervision or Assistance with Health-Related Tasks

Supervision or assistance with health-related tasks, as specified in the POC, may be provided to recipients (any health related procedures governed under the Nurse Practice Act where the direct service worker has received the required training pursuant to R.S. 37:1031-1034). Supervision or assistance includes, but is not limited to, medication administration.

Supervision or Assistance while Escorting/Accompanying with Community Tasks

Supervision or assistance may be provided to recipients while escorting or accompanying the recipient outside of the home to perform tasks, including IADLs, health maintenance or other needs as identified in the POC, and to provide the same supervision or assistance as would be rendered in the home.

Extension of Therapy Services

Licensed therapists may choose to instruct attendants on the proper way to assist the recipient in follow-up therapy sessions to reinforce and aid the recipient in the rehabilitative process. The attendant may also be instructed by a registered nurse to perform basic interventions with the recipient that would increase and optimize functional abilities for maximum independence in performing ADLs such as range of motion exercise. Instruction provided by licensed therapists and registered nurses must be documented.

Shared Personal Assistance Services

PAS may be provided by one worker for up to three CCW recipients who live together and have a common direct service provider (DSP).

Waiver recipients may share PAS staff when agreed to by the recipients and the health and welfare of each can be reasonably assured. Shared PAS is to be identified in the approved POC of each recipient. Reimbursement rates are adjusted accordingly. Due to the requirements of privacy and confidentiality, recipients who choose to share these services must agree to sign a confidentiality consent form to facilitate the coordination of services.

A.M./ P.M. Delivery Method

PAS may be provided through an “a.m./p.m.” delivery method. This delivery method provides PAS to the recipient at the beginning and/or end of the day.

PAS providers must be able to provide both regular and “a.m.” and “p.m.” PAS and cannot refuse to accept a CCW recipient solely due to the type of PAS delivery method that is listed on the POC.

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Standards

Providers must be licensed by the Health Standards Section (HSS) as a personal care attendant or a home health provider, comply with LDH rules and regulations, and be listed as a provider of choice on the FOC form before being approved to provide services.

A home health agency's DSW who renders PAS must be a qualified home health aide as specified in Louisiana's *Minimum Standards for Home Health Agencies* licensing regulations.

PAS providers must develop an individualized back-up staffing plan and agreement. This plan is used when the recipient's assigned PAS worker is unable to provide support due to unplanned circumstances including but not limited to emergencies which arise during a shift. The individualized plan and agreement shall be developed and maintained in accordance with OAAS policy. If the provider cannot meet the recipient's needs, the provider must submit "good cause" reasons to the OAAS Regional Office.

PAS providers shall ensure timely completion of the "OAAS Emergency Plan" for each waiver recipient they serve in accordance with OAAS Policy. (See Appendix B for information on accessing this form.)

Service Exclusions

PAS providers may not bill for this service until after the individual has been approved for the CCW.

PAS may not be billed at the same time of service as Adult Day Health Care (ADHC) and Caregiver Temporary Support services.

The following individuals are prohibited from being reimbursed for providing services to a recipient:

- The recipient's spouse;
- Recipient's curator;
- Recipient's tutor;
- Recipient's legal guardian;
- Recipient's responsible representative; or

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- The person to whom the recipient has given representative and mandate authority (also known as power of attorney).

Recipients are not permitted to receive PAS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services and providers are prohibited from providing and billing for services under these circumstances. Recipients may not live in the home of a direct support worker unless the direct support worker is related by blood or marriage to the recipient (see link for “Who Can Be a Direct Support Worker (DSW flowchart) for PAS and LT-PCS?” in Appendix B of this manual chapter). These provisions may be waived with prior written approval by OAAS or its designee on a case-by-case basis.

Service Limitations

Services must be approved by the OAAS Regional Office or its designee and be prior authorized. In order to bill for these services, the DSW must be with the recipient, be awake, alert and available to respond to the recipient’s immediate needs.

Assistance or support with ADL tasks shall not include teaching a family member or friend how to care for a recipient who requires assistance with any ADL.

The provision of PAS services outside of the recipient’s home does not include trips outside of the borders of the state without prior written approval of OAAS or its designee, through the POC or otherwise. The recipient’s written request must include a detailed explanation and be sent to OAAS, or its designee, at least 24 hours prior to the anticipated travel, when applicable.

PAS cannot be provided or billed at the same hours on the same day as shared PAS.

Recipients cannot receive PAS from the “a.m./p.m.” delivery method **on the same calendar day** as other PAS service delivery methods.

Recipients utilizing the “a.m./p.m.” delivery method must be provided with at least one hour, but no more than two hours, of service during each session. If both the “a.m.” and the “p.m.” sessions are provided, there must be at least a four-hour break between the two sessions.

Recipients receiving shared PAS must each be:

- Approved to receive CCW;
- Share the same residence; and

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- Have a common DSP.

Shared PAS cannot be billed on behalf of a recipient who was not present to receive the service.

“A.m./ p.m.” PAS cannot be shared.

A home health agency is limited to providing services within a 50-mile radius of its parent agency. This limit may be waived by the appropriate LDH authority on a case-by-case basis as needed.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval. When all requirements are met, the support coordinator provides a copy of the approved POC to the recipient and DSP. The DSP is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

Prior authorization for direct service provider agencies is based on a weekly cap and is released on a daily basis. Unused portions of the prior authorized weekly allotment may not be saved or borrowed from one week for use in another week.

Providers who are approved to provide services to more than one recipient under shared personal assistance services must bill separately for each recipient based on his/her POC. The recipient must be present to receive the service in order for the provider to bill for the service.

Shared and unshared PAS must be billed in 15 minute increments.

“A.m./p.m.” PAS must be billed per visit.

Adult Day Health Care Services

ADHC services provide a planned, diverse daily program of individual services and group activities structured to enhance the recipient’s physical functioning and to provide mental stimulation. ADHC services are furnished as specified in the POC at an ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the recipient.

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An ADHC center shall, at a minimum, furnish the following services:

- Assistance with ADLs;
- Health and nutrition counseling;
- Individualized exercise program;
- Individualized, goal-directed recreation programs;
- Health education;
- Medical care management;
- One nutritionally-balanced hot meal and a minimum of two snacks served each day;

NOTE: A provider may serve breakfast in place of a mid-morning snack. Also, providers must allow flexibility with their food and dining options to reasonably accommodate participants' expressed needs and preferences.

- Individualized health/nursing services that include the following:
 - Monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;
 - Administering medications and treatments in accordance with physicians' orders;
 - Developing and monitoring the individualized medication self-administration plans for each recipient;
 - Serving as a liaison between the recipient and medical resources including the treating physician.

NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

- Transportation between the recipient's place of residence and the ADHC in accordance with licensing standards.
 - The cost of transportation is included in the rate paid to providers of ADHC services. The recipient and his/her family may choose to transport

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the recipient to the ADHC center. Transportation provided by the recipient's family is not a reimbursable service;

NOTE: If transportation services are prescribed in any recipient's approved ISP and are not provided by the ADHC center, the center's reimbursement rate shall be reduced accordingly.

- Transportation to and from medical and social activities when the recipient is accompanied by ADHC center staff.

Standards

Providers must be licensed by HSS as an ADHC provider, enrolled in Medicaid as an ADHC provider, and must be listed as a provider on the FOC form prior to providing ADHC services. ADHC providers must comply with LDH rules and regulations,

ADHC centers are expected to provide transportation to any recipient within their licensed region.

Service Exclusions

ADHC providers shall not bill for this service until after the individual has been approved for the CCW.

ADHC service may not be billed at the same time of service as PAS and caregiver temporary support service.

Service Limitations

These services must be provided in the ADHC center that has been selected by the recipient.

ADHC services may be provided no more than 10 hours per day and no more than 50 hours per week (exclusive of transportation time to and from the ADHC center).

Reimbursement for this service requires PA.

Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC approval.

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OAAS Regional Office, or its designee, reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved POC to the recipient and ADHC provider. The ADHC provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

ADHC services must be billed in 15 minute units.

The use of the Electronic Visit Verification (EVV) system is mandatory for ADHC Services. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OAAS. The system is to be used to electronically “check in” and “check out” waiver recipients when they arrive and when they leave the ADHC center.

The transportation component of ADHC is exempt from this EVV mandatory requirement. However, using the EVV system to electronically record when recipients get on/off the ADHC transportation vehicle may be beneficial to the provider in preventing overlaps with other services and in completing cost reporting.

In the event of an overlap, the provider that uses the EVV system correctly (i.e., data has not been manually added or edited will receive priority for payment.

Caregiver Temporary Support Service

Caregiver temporary support service is furnished on a short-term basis because of the absence or need for relief of caregivers during the time they would normally provide unpaid care for the recipient. The purpose of caregiver temporary support is to provide relief to unpaid caregivers or principal caregivers of recipients who receive monitored in-home caregiver services to maintain the recipient’s informal support system. Federal financial participation is not claimed for the cost of room and board except when provided as part of caregiver temporary support service furnished in a facility approved by the state that is not a private residence.

Caregiver temporary support service is provided in the following locations:

- The recipient’s home or place of residence;
- Nursing facilities;
- Assisted living facilities;
- Respite centers; or
- ADHC centers.

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Caregiver temporary support service may be provided in the recipient's home by a Medicaid enrolled PCA or home health agency.

Caregiver temporary support service that is provided by nursing facilities, assisted living and respite centers must include an overnight stay.

Caregiver temporary support service that is provided by an ADHC center may not be provided for more than ten hours per day.

Standards

Providers must comply with LDH rules and regulations and be listed as a provider of choice on the FOC form as a caregiver temporary support provider prior to providing service.

Providers meet the following licensure requirements and Medicaid enrollment requirements:

Provider	Licensure and Enrollment Requirements
Respite Center	Respite Center license and Enroll as a Respite Center provider with applicable sub-specialty
Assisted Living Center	Assisted Living Center license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
Adult Day Health Care	Adult Day Health Care license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
Nursing Facility	Nursing Facility license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
PCA Agency	Personal Care Attendant license and Enroll as a Waiver Personal Care Attendant with applicable sub-specialty
Home Health Agency	Home Health Agency license and Enroll as a Home Health Agency with applicable sub-specialty

Service Exclusions

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Caregiver temporary support service may not be delivered/billed at the same time as PAS or ADHC.

Service Limitations

These services must be prior approved by the OAAS Regional Office or its designee.

Caregiver temporary support service may be utilized for no more than 30 calendar days or 29 overnight stays per POC year, for no more than 14 consecutive days or 13 consecutive overnight stays.

These service limits may be increased based on documented need.

Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC Approval.

For providers of overnight center-based services, the PA start date will be the morning after the first night of service, and the prior authorization end date will be the morning after the last night of service.

Caregiver temporary support service must be billed as follows:

Type of Provider	Billing Units
Waiver PCA Home Health ADHC	15 minute unit of service
Respite Care Centers Assisted Living Centers Nursing Facilities	Daily unit of service

Monitored In-Home Caregiving Services

Monitored in-home caregiving (MIHC) services are services provided to a recipient living in a private home with a principal caregiver. This service provides a community-based option of continuous care, supports, and professional oversight by promoting a cooperative relationship between the recipient, principal caregiver, professional staff of a MIHC agency provider, and the recipient's support coordinator.

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The principal caregiver is responsible for supporting the recipient to maximize the highest level of independence possible by providing necessary care and supports that may include:

- Supervision or assistance in performing ADLs;
- Supervision or assistance in performing IADLs;
- Protective supervision provided solely to assure the health and welfare of a recipient;
- Supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;
- Supervision or assistance while escorting/accompanying the recipient outside of the home to perform tasks, including instrumental ADLs, health maintenance or other needs as identified in the POC and to provide the same supervision or assistance as would be rendered in the home; and
- Extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

Standards

Monitored in-home caregiving providers must comply with LDH rules and regulations and be listed as a provider of choice on the FOC form as a MIHC services provider before being approved to provide services. Monitored in-home caregiving providers:

- Must be agency providers who employ professional nursing staff and other professionals to train and support caregivers to perform the direct care activities performed in the home;
- Must assess and approve the home in which services will be provided;
- Shall enter into contractual agreements with caregivers who they have approved and trained; and
- Must pay per diem stipends to caregivers.

Agency providers capture daily notes electronically to monitor the recipient's health and the

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caregiver's performance. The daily notes must be available to support coordinators and LDH upon request.

Service Exclusions

Unless the individual is also the spouse of the recipient, the following individuals are prohibited from being reimbursed as a MIHC principal caregiver:

- The recipient's curator;
- The recipient's tutor;
- The recipient's legal guardian;
- The recipient's responsible representative; or
- The person to whom the recipient has given representative and mandate authority (also known as power of attorney).

Limitations

Recipients electing monitored in-home caregiving services are not eligible to receive the following CCW services during the period of time that the recipient is receiving MIHC services:

- Personal assistance services;
- Adult day health care services; or
- Home delivered meal services.

MIHC providers shall not bill and/or receive payment on days that the recipient is attending or admitted to a program or setting (e.g., hospitals, nursing facilities, etc.) which provides in-home ADL or IADL assistance or while attending or admitted to a program or setting where such assistance is provided.

The provision of MIHC services outside of the borders of the state (e.g., temporary excursions, vacations, etc.) is prohibited without prior written approval by OAAS or its designee. The recipient's written request must include a detailed explanation sent to OAAS or its designee at least 24 hours prior to the anticipated travel, when applicable.

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Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC approval.

Reimbursement is based upon a two-tiered model that is designed to address the recipient's acuity.

Assistive Devices and Medical Supplies

Assistive devices and medical supplies are specialized medical equipment and supplies which include devices, controls, appliances or nutritional supplements specified in the POC that enable recipients to increase or maintain their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live or provide emergency response.

Assistive devices and medical supplies also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of assistive devices, and durable and non-durable medical equipment. This service includes a personal emergency response system (PERS) and other in-home telecommunication and/or computerized monitoring and medication management technology.

This service may also be used for routine maintenance or repair of specialized equipment. Batteries, extended warranties, and service contracts that are cost effective may be reimbursed. This includes medical equipment and necessary medical supplies not available under the State Plan that addresses recipient functional limitations addressed in the POC.

There must be an identified need for the assistive devices and/or medical supplies as indicated by the assessment, POC, and/or other SC documentation.

All costs associated with this service are subject to the recipient's annual budget allotment.

NOTE: Where applicable, recipients must use Medicaid state plan services, Medicare, or other available payers first. The recipient's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

Personal Emergency Response System (PERS)

PERS is an electronic device which enables the recipient to secure help in an emergency.

The unit is connected to the telephone line or a wireless communication device and is programmed to send an electronic message to a community-based 24-hour emergency response center when a "help" button is activated. This unit may either be worn by the recipient or

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installed in his/her home.

PERS services are appropriate for recipients who are cognitively and/or physically able to operate the system. PERS is a measure to promote the health and welfare of the recipient.

The PERS unit shall be rented from the PERS provider. Billing for this service involves an installation fee and a monthly maintenance fee which includes the cost of maintenance and training the recipient how to use the equipment. The PERS unit must be installed in the recipient's residence. Reimbursement of these services requires PA.

The PERS must be checked monthly by the provider to ensure it is functioning properly. The PERS battery/unit must be checked once every quarter by the support coordinator during the home visit.

Telecare

Telecare is a delivery of care services to recipients in their home by means of telecommunications and/or computerized devices to improve outcomes and quality of life, increase independence and access to health care, and reduce health care costs. Telecare services include:

- Activity and sensor monitoring;
- Health status monitoring; and
- Medication dispensing and monitoring.

Activity and Sensor Monitoring

This service is a computerized system that monitors the recipient's in-home movement and activity for health, welfare and safety purposes. The system is individually calibrated based on the recipient's typical in-home movements and activities. The provider agency is responsible for monitoring electronically-generated information, for responding as needed, and for equipment maintenance. At a minimum, the system shall:

- Monitor the home's points of egress;
- Detect falls;
- Detect movement or the lack of movement;

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- Detect whether doors are opened or closed; and
- Provide a push-button emergency alert system.

NOTE: Some systems may also monitor the home's temperature.

Health Status Monitoring

This service collects health-related data to assist the health care provider in assessing the recipient's health condition and in providing recipient education and consultation. The data is collected electronically from the recipient using wireless technology or a phone line and assists the healthcare provider in assessing the recipient's health. Health status monitoring may be beneficial to recipients with chronic medical conditions such as congestive heart failure, diabetes or pulmonary disease in monitoring the recipient's:

- Weight;
- Oxygen saturation measurements (pulse oximetry); and
- Vital signs (pulse, blood pressure, etc.).

Peripheral equipment used must be capable of interfacing with the telecare health status monitoring equipment.

Billing for this service includes a one-time installation fee that covers the cost of equipment installation and removal. A monthly maintenance fee includes a face-to-face visit by a registered nurse should the collected data warrant a visit.

Should the recipient require additional visits by a registered nurse during the month, those visits must be authorized with approval from the support coordinator and will be paid at the waiver's Nursing Service rates. If the data indicates a potential emergency, the provider may dispatch a nurse without consultation for approval with the support coordinator; however, the support coordinator must be contacted by the next business day to request retroactive approval.

Medication Dispensing and Monitoring

This service assists the recipient by dispensing medication and monitoring medication compliance. A remote monitoring system is individually pre-programmed to dispense and monitor the recipient's compliance with medication therapy. The provider or family caregiver is notified when there are missed doses or non-compliance with medication therapy.

Dispensing and monitoring devices must have the ability to send text or e-mail messages to the

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recipient's caregiver should the medication not be taken or there is a problem with the equipment.

Dispensing and monitoring systems may include a web-based component for dosage programming, monitoring, and/or communication.

Standards

Assistive devices and certain medical equipment and supplies providers must:

- Be a licensed home health agency or a DME provider;
- Comply with LDH rules and regulations;
- Be enrolled in Medicaid to provide these services; and
- Be listed as a provider of choice on the FOC form.

PERS providers must:

- Comply with OAAS' standards for participation;
- Be enrolled as the applicable Medicaid provider type; and
- Be listed as a provider of choice on the FOC form.

The PERS provider must install and support PERS equipment in compliance with all of the applicable federal, state, parish and local laws and regulations, as well as meet manufacturer's specifications, response requirements, maintenance records, and recipient education.

PERS devices must meet Federal Communications Commission standards or Underwriter's Laboratory (UL) standards or equivalent standards.

Telecare service providers must meet the following system requirements:

- Be UL listed/certified or have 501(k) clearance;
- Be web-based;
- Be compliant with the requirements of the Health Insurance Portability and

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Accountability Act (HIPAA);

- Have recipient specific reporting capabilities for tracking and trending;
- Have a professional call center for technical support based in the United States; and
- Have on-going provision of web-based data collection for each recipient, as appropriate. This includes response to recipient self-testing, manufacturer's specific testing, self-auditing and quality control.

All telecare providers must make documentation collected from telecare services available to the support coordinator and OAAS upon request.

Service Exclusions

No experimental items are allowed.

Service Limitations

Services must be pre-approved by the OAAS Regional Office or its designee and be prior authorized.

Services must be based on a verified need of the recipient and the service must have a direct or remedial benefit with specific goals and outcomes.

The benefit must be determined by an independent assessment on any item that costs over \$500 and on all communication devices, mobility devices, and environmental controls.

Independent assessments are done by the appropriate professional, e.g., an occupational therapist, physical therapist, and/or speech/language pathologist, who has no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

All items must reduce reliance on other Medicaid State Plan or waiver services.

All items must meet applicable standards of manufacture, design and installation.

The items must be on the POC developed by the support coordinator and are subject to approval by OAAS Regional Office or its designee.

A recipient will not be able to simultaneously receive telecare activity and sensor monitoring

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services and traditional PERS services.

NOTE: Where applicable, recipients must use Medicaid State Plan, Medicare, or other available payers first. The recipient's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

Reimbursement

Assistive devices and medical supplies providers may not bill for this service until after the recipient has been approved for the CCW.

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

Billing for PERS or telecare services involves an installation fee and a monthly maintenance fee. Only one claim for each month is allowed. Claims may be span-dated at the discretion of the provider. Partial months shall not be billed.

The monthly maintenance fee for all telecare services includes:

- Delivering, furnishing, maintaining and repairing/replacing equipment on an ongoing basis. This may be done remotely as long as all routine requests are resolved within three business days;
- Monitoring of recipient-specific service activities by qualified staff;
- Training the recipient and/or the recipient's responsible representative in the use of the equipment;
- Cleaning and storing equipment;
- Providing remote teaching and coaching as necessary to the recipient and/or caregiver(s); and
- Analyzing data, developing and documenting interventions by qualified staff based on information/data reported.

If a recipient who receives PERS or telecare service moves to a different location or changes providers, reimbursement for a second installment is permissible.

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Home Delivered Meals

The purpose of home delivered meals is to assist recipients in meeting their nutritional needs in support of the maintenance of self-sufficiency and enhancing their quality of life.

Home delivered meals includes up to two nutritionally balanced meals per day to be delivered to the home of a recipient who is:

- Unable to leave the home without assistance;
- Unable to prepare his/her own meals; and/or
- Has no responsible caregiver in the home.

The home delivered meal is to provide the recipient a minimum of one-third of the current recommended dietary allowance (RDA) as adopted by the United States Department of Agriculture (USDA). The provision of home delivered meals does not provide a full nutritional regimen.

Standards

All in-state providers must meet all of the Louisiana Office of Public Health certification, permit and inspection requirements for retail food preparation, processing, packaging, storage and distribution.

All out-of-state providers must meet retail food preparation, processing, packaging, storage and distribution requirements of the USDA and the state of operation.

All providers must be enrolled in Medicaid and comply with LDH rules and regulations.

Service Limitations

Meals are limited to two per day. It is permissible for recipients to have some meals delivered daily and others delivered in bulk by different providers as long as the maximum of two meals per day is not exceeded.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

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The data contractor will issue annual PAs. The PA will be for a minimum of four meals per week, up to a maximum of 14 meals per week, not to exceed the limit of two meals per day. One unit of service equals one meal.

Providers will be allowed to span date bill for up to a two weeks supply of meals.

Nursing

Nursing services are services that are medically necessary and may be provided efficiently and effectively by a nurse practitioner, registered nurse (RN), or a licensed practical nurse (LPN) working under the supervision of an RN. Nursing services must be provided within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may include periodic assessment of the recipient's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers.

Nursing services may also include regular, ongoing monitoring of a recipient's fragile or complex medical condition as well as the monitoring of a recipient with a history of noncompliance with medication or other medical treatment needs.

Nursing services may also be used to assess a recipient's need for assistive devices or home modifications, training the recipient and family members in the use of the purchased devices, and training of DSWs in tasks necessary to carry out the POC.

All services must be based on a verified need of the recipient and must have a direct or remedial benefit to the recipient with specific goals and outcomes.

Standards

Providers must be enrolled in Medicaid as a nursing provider, comply with LDH rules and regulations, and must be listed as a provider of choice on the FOC form.

Nursing services provided must be within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may be provided by a nurse practitioner, an RN or LPN employed by a home health agency.

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Service Exclusions

Nursing providers shall not bill for this service until after the recipient has been approved for the CCW.

Nursing services shall not be provided when the recipient is an inpatient at a hospital.

Service Limitations

Services must be approved by the OAAS Regional Office or its designee and be prior authorized.

Services must be based on a verified need of the recipient.

Services must have a direct or remedial benefit to the recipient with specific goals and outcomes.

Providers are not required to have a doctor's order for an assessment and treatment/service before this service is reimbursed by the CCW. Providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

NOTE: Where applicable, recipients must use Medicare or other available payers first. The recipient's preference for a certain staff or agencies is not grounds for declining another payer in order to access waiver services.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

The data contractor will issue PAs for no more than six months.

Skilled Maintenance Therapy (Physical, Occupational, Respiratory and Speech/Language)

Skilled maintenance therapy includes physical therapy, occupational therapy, respiratory therapy and/or speech and language therapy that may be received by CCW recipients in their home.

Therapy services provided to recipients under the waiver are not necessarily tied to an episode of illness or injury and instead focus primarily on the recipient's functional need for maintenance of or reducing the decline in the recipient's ability to carry out ADLs.

Skilled maintenance therapies may also be used to assess a recipient's need for assistive devices

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or home modifications, training the recipient and family members in the use of the purchased devices, performance of in-home fall prevention assessments, and participation on the POC planning team. Services may be provided in the recipient's home or in a variety of locations as approved by the POC planning team.

Physical Therapy

Physical therapy services promote the maintenance of or reduction in the loss of gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include:

- Professional assessments;
- Evaluations and monitoring for therapeutic purposes;
- Physical therapy treatments and interventions;
- Training regarding physical therapy activities;
- Use of equipment and technologies;
- Designing, modifying or monitoring the use of related environmental modifications;
- Designing, modifying, and monitoring the use of related activities supportive to the POC goals and objectives; or
- Consulting or collaborating with other service providers or family members, as specified in the POC.

Occupational Therapy

Occupational therapy services promote the maintenance of, or reduction in, the loss of fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology.

Specific services may include:

- Teaching of daily living skills;
- Development of perceptual motor skills and sensory integrative functioning;

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- Design, fabrication, or modification of assistive technology or adaptive devices;
- Provision of assistive technology services;
- Design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;
- Use of specifically designed crafts and exercise to enhance function;
- Training regarding occupational therapy activities; and
- Consulting or collaborating with other service providers or family members as specified in the POC.

Speech Language Therapy

Speech language therapy services preserve abilities for independent function in communication, facilitate oral motor and swallowing function, facilitate use of assistive technology, and/or prevent progressive disabilities.

Specific services may include:

- Identification of communicative or oropharyngeal disorders;
- Prevention of communicative or oropharyngeal disorders;
- Development of eating or swallowing plans and monitoring their effectiveness;
- Use of specifically designed equipment, tools, and exercises to enhance function;
- Design, fabrication, or modification of assistive technology or adaptive devices;
- Provision of assistive technology services;
- Adaptation of the recipient's environment to meet his/her needs;
- Training regarding speech language therapy activities; and
- Consulting or collaborating with other service providers or family members as specified in the POC.

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Standards

Skilled maintenance therapy services may be provided by home health agencies that employ licensed therapists and comply with LDH rules and regulations.

Service Exclusions

Providers may not bill for services until after the individual has been approved for the CCW program and prior authorization has been issued.

Skilled maintenance therapies shall not be provided when the recipient is an inpatient at a hospital.

Service Limitations

Services must be based on a verified need of the recipient.

The service must have a direct or remedial benefit to the recipient with specific goals and outcomes.

Providers are not required to have a doctor's order for assessments or treatment/services before this service is reimbursed through the CCW Program; however, providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

NOTE: Where applicable, the recipient must use Medicare, Medicaid State Plan, or other available payers first. The recipient's preference for a certain therapist or agency is not grounds for declining another payer in order to access waiver services.

Reimbursement

Payment shall not be authorized until the OAAS Regional Office or its designee gives final POC approval.

A prior authorization period will not exceed six months.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

These housing support services assist waiver recipients to obtain and maintain successful tenancy

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in Louisiana's Permanent Supportive Housing (PSH) Program.

Housing Transition or Crisis Intervention Services

Housing transition or crisis intervention services enable recipients who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing or provide assistance at any time the recipient's housing is placed at risk (e.g., eviction, loss of roommate or income). This service includes the following components:

- Conducting a housing assessment that identifies the recipient's preferences related to housing (type and location of housing, living alone or living with someone else, accommodations needed, and other important preferences), and identifying the recipient's needs for support to maintain housing, including:
 - Access to housing;
 - Meeting the terms of a lease;
 - Eviction prevention;
 - Budgeting for housing/living expenses;
 - Obtaining/accessing sources of income necessary for rent;
 - Home management;
 - Establishing credit; and
 - Understanding and meeting the obligations of tenancy as defined in the lease terms.
- Assisting the recipient to view and secure housing as needed. This may include:
 - Arranging or providing transportation;
 - Assisting in securing supporting documents/records;
 - Assisting in completing/submitting applications;
 - Assisting in securing deposits; and
 - Assisting in locating furnishings.
- Developing an individualized housing support plan based upon the housing assessment that:
 - Includes short and long-term measurable goals for each issue;
 - Establishes the recipient's approach to meeting the goal(s); and
 - Identifies where other provider(s) or services may be required to meet the goal(s).
- Participating in the development of the POC and incorporating elements of the

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housing support plan;

- Looking for alternatives to housing if permanent supportive housing is unavailable to support completion of transition; and
- Communicating with the landlord or property manager regarding the recipient's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager.

If at any time the recipient's housing is placed at risk (e.g., eviction, loss of roommate or income), housing transition or crisis intervention services will provide supports to retain housing or locate and secure housing to continue community-based supports including locating new housing, sources of income, etc.

Housing Stabilization Services

Housing stabilization services enable waiver recipients to maintain their own housing as set forth in the recipient's approved POC. Services must be provided in the home or a community setting. This service includes the following components:

- Participating in the POC renewal and updates as needed to incorporate elements of the housing support plan.
- Providing supports and interventions per the individualized housing support plan. If additional supports or services are identified as needed outside the scope of housing stabilization services, the needs must be communicated to the support coordinator.
- Providing ongoing communication with the landlord or property manager regarding:
 - The recipient's disability;
 - Accommodations needed; and
 - Components of emergency procedures involving the landlord or property manager.
- Updating the housing support plan annually or as needed due to changes in the recipient's situation or status.

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Standards

Housing transition or crisis intervention services and housing stabilization services may be provided by permanent supportive housing agencies that are enrolled in Medicaid to provide these services, comply with LDH rules and regulations and are listed as a provider of choice on the FOC form.

Service Exclusions

These services are only available upon referral from the support coordinator and are not duplicative of other waiver services, including support coordination. These services are only available to recipients who are residing in, or who are linked for the selection process of, a State of Louisiana permanent supportive housing unit.

Service Limitations

Up to 96 units of housing transition or crisis intervention service can be used per POC year without written approval from the support coordinator.

No more than 168 units of combined housing transition or crisis intervention services and housing stabilization services can be used per POC year without written approval from the support coordinator.

Reimbursement

Payment will not be authorized until the OAAS Regional Office or its designee gives final POC approval.

OAAS Regional Office or its designee reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved POC to the recipient and the permanent supportive housing provider. The permanent supportive housing provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided. Services must be billed in 15 minute units.

Hospice and Waiver Services

Recipients who receive waiver services may also be eligible for Medicaid hospice services.

Recipients who elect hospice services may choose to elect Community Choices Waiver (CCW) and hospice services concurrently. The hospice provider and support coordination agency must coordinate CCW and hospice services when developing the recipient's plan of care (POC). All

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core hospice services must be provided in conjunction with CCW services. When electing both services, the hospice provider must develop the POC with the recipient, the recipient's care giver and the support coordination agency. The POC must clearly and specifically detail the CCW and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the recipient's daily needs are being met. This will involve coordinating services where the recipient may receive services each day of the week.

The hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling.

Once the hospice program requirements are met, then CCW Personal Assistance Services (PAS) can be utilized for those personal care tasks covered in the CCW program for which the recipient requires assistance.

Waiver Services Payable While in a Nursing Facility

Certain CCW services are payable when transitioning from a nursing facility or for a recipient during a temporary stay in a nursing facility. (See Appendix F for a complete list of the CCW services.)

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SECTION 7.2: SELF-DIRECTION OPTION**PAGE(S) 3**

SELF-DIRECTION OPTION

Self-direction is a voluntary service delivery option which allows recipients to coordinate the delivery of personal assistance services (PAS) under the Community Choices Waiver through an individual direct support professional rather than a licensed, enrolled provider agency. The recipient becomes the employer of the direct service worker(s) they choose to hire to provide their supports. As the employer, the recipient or his/her authorized representative is responsible for recruiting, training, supervising, and managing the direct service worker(s). Recipients may choose to self-direct all or part of their PAS.

A required component of this option is the use of an approved contracted fiscal/employer agent who will perform the recipient's employer-related payroll functions. A portion of the recipient's overall budget is used to offset administrative costs for the fiscal management agency. After this portion has been deducted from the overall budget, the remainder is the budget amount for the individual recipient's services.

Support coordination services are also required for the development of the plan of care, budget planning, ongoing evaluation of supports and services, and for organizing the various resources the recipient needs. (See Appendix B for information on accessing the *Louisiana Department of Health and Hospitals, Office of Aging and Adult Services Self Direction Option Community Choices Waiver Employer Handbook*.)

Recipients participating in the self-direction option must:

- Be a Community Choices Waiver recipient;
- Be able to participate in this option without a lapse or decline in quality of care or an increased risk to health and welfare;
- Complete the mandatory overview training including rights and responsibilities of self-direction offered by the support coordinator;
- Understand the rights, risks, and responsibilities of self-direction and managing and using an individual budget, or if unable to make decisions independently, have a willing decision maker (responsible representative) who understands the rights, risks, and responsibilities of managing the care and supports of the recipient within his/her individual budget; and
- Comply with all state and federal laws and regulations including but not limited to minimum wage and overtime requirements.

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SECTION 7.2: SELF-DIRECTION OPTION**PAGE(S) 3**

Direct care service workers must be at least 18 years of age on the date of hire and complete all training mandated by the Office of Aging and Adult Services (OAAS) within the required timelines. The OAAS, or its designee, will verify this compliance.

Termination of the Self-Direction Option

Termination of participation in the self-direction option requires a revision of the plan of care by the support coordinator to eliminate the fiscal agent and add the recipient's choice of a Medicaid-enrolled waiver service provider(s). Termination may be either voluntary or involuntary.

Voluntary Termination

Recipients utilizing the self-direction option can choose to return to traditional provider agency management of services at any time. The support coordinator will assist the recipient in transitioning to a traditional provider agency.

Recipients who return to traditional provider agency services must remain with the service provider for at least 90 days (3 months) before opting to return to the self-direction option.

Involuntary Termination

Involuntary termination of the self-direction option may occur if:

- The Office of Aging and Adult Services determines that the health or welfare of the recipient is compromised by continued participation in the self-direction option;
- There is evidence that the recipient is no longer able to direct his or her care, and it is determined there is no responsible representative to direct the care of the recipient;
- If there is misuse of public funds by the participant or the responsible representative;
- The recipient or the authorized representative places barriers to the payment of the salaries and related employment taxes of direct support staff over three payment cycles in a one year period;
- The recipient or the responsible representative fails to:
 - Follow the POC;

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SECTION 7.2: SELF-DIRECTION OPTION**PAGE(S) 3**

- Provide documentation of services and expenditures; or
- Cooperate with the fiscal agent or support coordinator in preparing any additional documentation of services or expenditures; or
- The recipient or the responsible representative violates Medicaid program rules or guidelines of the self-direction option;
- There is proof of misuse of public funds by the recipient or responsible representative; and/or
- If the recipient does not receive self-directed PAS for 90 days or more.

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SECTION 7.3: RECIPIENT REQUIREMENTS**PAGE(S) 4**

RECIPIENT REQUIREMENTS

The Community Choices Waiver program is only available to individuals who meet the following criteria:

- Meet initial and continued Medicaid eligibility criteria,
- Are age 65 years or older, **OR** 21 through 64 years of age with a disability that meets Medicaid standards or the Social Security Administration's disability criteria,
- Meet initial and continued nursing facility level of care requirements,
- Have their name on the Request for Services Registry for the Community Choices Waiver, and
- Have a Plan of Care sufficient to:
 - Reasonably assure that the health and welfare of the waiver applicant can be maintained in the community with the provision of waiver services, and
 - Justify that the Community Choices Waiver services are appropriate, cost effective and represent the least restrictive environment for the individual.

Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria above will result in denial of or discharge from admission to the Community Choices Waiver.

NOTE: An individual may only be certified to receive services from one home and community-based waiver program at a time.

Request for Services Registry

The Department of Health and Hospitals (DHH) is responsible for the Request for Services Registry (RFSR), hereafter referred to as "the registry," for the Community Choices Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll-free telephone number which is maintained by the Office of Aging and Adult Services (OAAS).

Requests for Community Choices Waiver services shall be accepted from the following:

- The applicant,

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SECTION 7.3: RECIPIENT REQUIREMENTS**PAGE(S) 4**

- An individual who is legally responsible for the applicant, or
- A responsible representative designated by the applicant to act on his/her behalf.

Individuals will be screened to determine whether they meet nursing facility level of care. Only individuals who meet this criterion will be added to the registry. The individual's name is placed on the registry in request date order.

Community Choices Waiver opportunities are offered to individuals on the registry according to priority groups. The following groups shall have priority in the order listed:

- Individuals with substantiated cases of abuse or neglect who are referred by Adult Protective Services (APS) or Elderly Protective Services (EPS) who, without Community Choices Waiver services, would need institutional placement to prevent further abuse and neglect as determined by OAAS review,
- Individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS), if the designated slots reserved for such individuals are all filled,
- Individuals who are residing in a state of Louisiana permanent supportive housing unit or who are linked for the state of Louisiana permanent supportive housing process,
- Individuals admitted to a nursing facility who are approved for a stay of more than 90 days,
- Individuals who are not presently receiving home and community-based services under another approved Medicaid waiver program, including, but not limited to:
 - Adult Day Health Care Waiver,
 - New Opportunities Waiver (NOW),
 - Supports Waiver, or
 - Residential Options Waiver (ROW), and
- All other eligible individuals on the registry, by date of first request for services.

Community Choices Waiver expedited opportunities may also be offered to qualified Long-Term Personal Care Services (LT-PCS) recipients.

If an applicant is determined to be ineligible for any reason at the time an offer is made, the next individual on the registry, based on the above stated prioritization, is notified and the process

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continues until an individual is determined eligible. A Community Choices Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

Seventy-five waiver opportunities are reserved for individuals diagnosed with ALS. Qualifying individuals who have been diagnosed with ALS are offered one of these Community Choices Waiver opportunities on a first-come, first-serve basis.

Expedited Waiver Opportunities

Notwithstanding the priority group provisions, a limited number of waiver opportunities may be granted to qualified individuals who require expedited waiver services. These individuals shall be offered an opportunity on a first-come, first-served basis. To be considered for an expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of services allowable under the LT-PCS Program and require institutional placement, unless offered an expedited waiver opportunity. The following criteria shall be considered in determining whether or not to grant an expedited waiver opportunity:

- Support through other programs is either unavailable or inadequate to prevent nursing facility placement,
- The death or incapacitation of an informal caregiver leaves the person without other supports,
- The support from an informal caregiver is not available due to a family crisis,
- The person lives alone and has no access to informal support, or
- For other reasons, the person lacks access to adequate informal support to prevent nursing facility placement.

Admission Denial or Discharge Criteria

Failure of the individual to cooperate in the eligibility determination process or to meet any of the following criteria will result in denial of admission to/or discharge from the Community Choices Waiver.

Admission shall be denied or the recipient shall be discharged from the waiver if any of the following conditions are determined:

- The individual does not meet the target population criteria,

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SECTION 7.3: RECIPIENT REQUIREMENTS

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- The individual does not meet the criteria for Medicaid eligibility,
- The individual does not meet the criteria for a nursing facility level of care,
- The recipient resides in another state or has a change of residence to another state,
- Continuity of services is interrupted as a result of the recipient not receiving and/or refusing Community Choices Waiver services (exclusive of support coordination services) for a period of 30 consecutive days,

NOTE: Continuity of services will not apply when interruptions are due to a recipient being admitted to an acute care hospital, rehabilitation hospital or nursing facility so long as the stay does not exceed 90 consecutive days.

- The health and welfare of the individual cannot be reasonably assured through the provision of the Community Choices Waiver services,
- The individual fails to cooperate in the eligibility determination process or in the development or performance of the Plan of Care,
- The individual fails to maintain a safe and legal home environment, or
- It is not cost effective to serve the individual in the Community Choices Waiver.

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SECTION 7.4: RECIPIENT RIGHTS/RESPONSIBILITIES **PAGE(S) 5**

RECIPIENT RIGHTS AND RESPONSIBILITIES

Recipients have specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs. Support coordinators and service providers must assist recipients to exercise their rights and responsibilities. Every effort must be made to assure that applicants or recipients understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid to adhere to the following policies on recipient rights.

Each individual who requests Community Choices Waiver services has the option to designate a responsible representative to assist or act on his/her behalf in the process of accessing and/or maintaining Community Choices Waiver services. The responsible representative may not concurrently serve as a responsible representative for more than two recipients in a Medicaid home and community-based service program that is operated by the Office of Aging and Adult Services which includes, but is not limited to:

- The Program of All-Inclusive Care for the Elderly (PACE),
- Long-term Personal Care Services (LT-PCS),
- The Community Choices Waiver, and
- The Adult Day Health Care (ADHC) Waiver

Freedom of Choice of Program

Individuals who have been offered waiver services have the freedom to choose between institutional care services and community-based services. They have the responsibility to participate in the evaluation process which includes providing the medical and other pertinent information or assisting in obtaining it for use in the person-centered planning process and certification for services. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

Freedom of Choice of Providers

Recipients have the freedom of choice to select their service providers. Recipients may make provider changes based on the following schedule:

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Type of Service Provider	Without Good Cause	With Good Cause
Transition Service	Not applicable	Not applicable
Personal Assistance Service	Every 3 months	Any time
Transition Intensive Support Coordination Support Coordination Environmental Accessibility Adaptation Adult Day Health Care Skilled Maintenance Therapy Nursing Assistive Devices and Medical Supplies Caregiver Temporary Support Service Home Delivered Meals Monitored In-Home Caregiving Services	Every 6 months	Any time

NOTE: The change is based on a calendar year with the change effective beginning the first day of the following quarter.

The Office of Aging and Adult Services (OAAS), or its designee will provide recipients with their choice of support coordination providers.

Support coordinators will provide recipients with their choice of all other waiver service providers and help arrange and coordinate all the services on the Plan of Care.

Adequacy of Care

All recipients in Louisiana's home and community-based waiver programs have the right to choose and receive the services necessary to support them to live in a community setting. Services are arranged and coordinated through the support coordination system and approved by the OAAS regional office or its designee. Administrative limits are placed on some services according to the waiver that is authorized by the Center for Medicare and Medicaid Services (CMS).

Recipients have the responsibility to request only those services they need and not request excess services, or services for the convenience of providers or support coordinators. Units of service are not "saved up". The services are certified as medically necessary for the recipient to be able

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SECTION 7.4: RECIPIENT RIGHTS/RESPONSIBILITIES **PAGE(S) 5**

to stay in the community and are revised on the Plan of Care as each recipient's needs change.

Participation in Care

Each recipient shall participate in assessment and person-centered planning meetings and any other meeting involving decisions about services and supports to be provided as part of the waiver process. Each recipient may choose whether or not providers attend assessment and planning meetings. Person-centered planning will be utilized in developing all services and supports to meet the recipient's needs. By taking an active part in planning his/her services, the recipient is better able to utilize the available supports and services. The recipient shall report any service need change to his/her support coordinator and service provider(s).

Changes in the amount of services must be requested by the recipient and submitted by the support coordinator at least 14 calendar days before taking effect, except in emergencies. Providers may not initiate a request for change/adjustment of service(s) without the participation and consent of the recipient. These changes must be approved by the OAAS regional office or its designee.

Voluntary Participation

Recipients have the right to refuse services, to be informed of the alternative services available to them, and to know the consequences of their decisions. Therefore, a recipient will not be required to receive services that he/she may be eligible for but does not wish to receive. The intent of the Community Choices Waiver is to provide community-based services to individuals who would otherwise require care in a nursing facility. Providers must reasonably assure that the recipient's health and welfare needs are met. As part of the planning process, methods to comply with these assurances may be negotiated to suit the recipient's needs and outcomes.

Quality of Care

Each recipient of home and community-based waiver services has the right to receive services from providers whose employees have been trained and are qualified to provide them. In cases where services are not delivered according to the approved Plan of Care or there is abuse or neglect on the part of the service provider, the recipient shall follow the complaint and/or abuse/neglect reporting procedures. Recipients and providers shall cooperate in the investigation and resolution of the reported incident. Recipients may not request providers to perform tasks that are illegal or inappropriate, and they may not violate the rights of other recipients.

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SECTION 7.4: RECIPIENT RIGHTS/RESPONSIBILITIES **PAGE(S) 5**

Civil Rights

Providers shall operate in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. This means that individuals are accepted and that all services and facilities are available to persons without regard to race, color, religion, age, sex, or national origin. Recipients have the responsibility to cooperate with their providers by not requesting services which in any way violate these laws.

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the Community Choices Waiver recipients. In order to maintain eligibility, recipients have the responsibility to inform BHSF of changes in their income, resources, address, and living situation.

The OAAS or its designee is responsible for approving level of care and waiver certification. In order to maintain this certification, recipients have the responsibility to inform the OAAS, through their support coordinator, of any significant changes which may affect their level of care or waiver certification. Providers may not approve or deny the recipient's level of care or waiver certification.

Grievances/Fair Hearings

The recipient has a responsibility to bring problems to the attention of providers or the Department of Health and Hospitals and to participate in the grievance or appeal process.

All support coordination and direct service providers shall have grievance procedures through which recipients may grieve the supports or services they receive. Recipients must be advised of the right to file a grievance, their rights to a fair hearing and the process for an appeal through the Division of Administrative Law. In the event of a fair hearing, a representative of the support coordination agency shall participate by telephone, or if requested, appear in person and participate in the proceedings.

An appeal by the recipient may be filed at the local Medicaid Office or with the Division of Administrative Law. (See Appendix A for contact information)

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SECTION 7.4: RECIPIENT RIGHTS/RESPONSIBILITIES **PAGE(S) 5**

Complaint/Help Lines

Toll-free numbers are available to provide waiver assistance, clarification of waiver services, and reporting complaints regarding waiver services including reports of abuse, neglect and exploitation. (See Appendix A for contact information)

These toll-free numbers are accessible within the State of Louisiana.

Rights and Responsibilities Form

The support coordinator is responsible for reviewing the recipient's rights and responsibilities with the recipient and/or his/her personal representative as part of the initial intake process and at least annually thereafter. (See Appendix B for information on accessing the *Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Home and Community-Based Waiver Services (HCBWS)* form)

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SECTION 7.5: SERVICE ACCESS AND AUTHORIZATION PAGE(S) 10

SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Community Choices Waiver (CCW) opportunity or an existing opportunity is vacated, the individual who meets the criteria for one of the priority groups, or whose date is reached on the Request for Services Registry (RFSR) shall receive a written notice indicating that a waiver opportunity is available. The applicant will receive a waiver offer packet that includes a Community Choices Waiver Services Decision Form and a Support Coordination Agency Freedom of Choice (FOC) form.

The applicant must complete and return the packet to indicate interest in receiving a CCW opportunity and to determine if he/she meets the preliminary level of care criteria and/or any additional program requirements.

If the applicant meets the preliminary level of care and/or additional program requirements, he/she will be linked to a support coordination agency. A support coordinator will be assigned to conduct an in-home assessment with the applicant and inform him/her of all available services. The support coordinator shall also assist the applicant as needed with the financial eligibility process conducted by the Medicaid parish office.

Once it has been confirmed that the applicant meets the level of care requirements for the program, a second home visit is made to finalize the Plan of Care (POC). The following must be addressed in the POC:

- The types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the recipient in the community;
- The individual cost of each waiver service; and
- The total cost of waiver services covered by the POC.

Provider Selection

The support coordinator must present the recipient with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the POC. The support coordinator will have the recipient or responsible representative complete the provider FOC form. FOC will be offered initially and annually thereafter for each identified waiver service.

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The support coordinator is responsible for:

- Notifying the selected providers that they have been chosen by the recipient to provide the necessary services;
- Securing from selected providers a commitment to provide services, assessments and/or plans, (based on the provider's specific type of service); and
- Forwarding the POC packet to the Office of Aging and Adult Services (OAAS) regional office or its designee for review and approval following the established protocol.

NOTE: The authorization to provide service is contingent upon approval by the OAAS regional office or its designee.

Prior and Post Authorization

All services under the CCW must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid recipient by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all edits contained within the claims payment process, the recipient's continued Medicaid and waiver eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a recipient, provider, service code, established quantity of units, and for specific dates of service.

PA revolves around the POC document, which means that only the service codes and units specified in the approved POC will be prior authorized. Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The service provider is responsible for the following activities:

- Checking prior authorizations to verify that all prior authorizations for services match the approved services in the recipient's POC. Any mistakes must be immediately corrected to match the approved services in the POC;

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- Verifying that the case record documentation is completed correctly and that services were delivered according to the recipient's approved POC prior to billing for the service;
- Verifying that services were documented as specified in Section 7.8 – Record Keeping and are within the approved service limits as identified in the recipient's POC prior to billing for the service;
- Completing data entry into the direct service provider data system using the Louisiana Service Reporting Systems (LaSRS);
- Inputting the correct date(s) of service, authorization numbers, provider number, and recipient number in the billing system;
- Billing only for the services that were delivered to the recipient and are approved in the recipient's POC;
- Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary with each payment; and
- Checking billing records to ensure that the appropriate payment was received.

NOTE: Service providers have one-year timely filing billing requirement under Medicaid regulations.

Some services require post authorization before the provider is able to bill for services rendered. Once post authorization is granted, the service provider may bill the LDH fiscal intermediary for the appropriate units of service.

Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

Support Coordination

Authorization for support coordination service is issued by the data contractor through two authorization periods for the POC year. A service unit is one month and each authorization covers a five to seven-month period, or five to seven service units. At the end of the month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

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Transition Intensive Support Coordination

Authorization for transition intensive support coordination is issued upon receipt of the POC (provisional or initial).

A service unit is one month. The authorization includes a unit of service for each month with a maximum of six units of service per authorization. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances as determined and approved by OAAS.

Transition Services

Only one authorization for transition services is issued. The authorization period is the effective date of the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revised) that includes the transition services, the receipts for the purchases and the “Transition Service Form (TSF)” are sent to the data contractor. (See Appendix B for a copy of this form.)

The data contractor issues and releases the PA to the support coordination agency upon receipt of complete and accurate information. The support coordination agency is responsible for reimbursing the purchaser (recipient, family, provider, own agency, etc.) upon receipt of reimbursement.

Environmental Accessibility Adaptation

When the data contractor receives a POC (provisional, initial or revised) that indicates a need for an environmental accessibility adaptation, an authorization is issued for a basic assessment to the assessor/inspector/approver, hereafter referred to as the assessor. After the data contractor receives documentation that the assessor has completed the assessment, the PA for the basic assessment and approval services is released.

If the basic assessment indicates the need for an environmental accessibility adaptation, the data contractor will issue the following two authorizations upon receipt of the revised POC:

- An authorization for the final assessment and approval to the assessor; and
- An authorization for the installation/completion of the adaptation to the provider completing the modification.

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Upon receipt of documentation that these tasks have been completed, the data contractor will release the PAs for payment.

NOTE: If an assessor is not available, the OAAS regional office is responsible for giving prior approval for both installation/completion of the adaptation and for satisfactory completion of the adaptation.

Personal Assistance Services

An annual authorization of personal assistance services (PAS) is issued upon receipt of the POC (initial or revised). The authorization is based on the approved POC.

A unit of service is:

Unit of Service	Type of Delivery Method
Per visit	A.M./P.M.
15 minutes	Traditional

The authorization, which is based on the prior authorized weekly cap, is released on a daily basis after service is provided and documented in the LaSRS system. The prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Saturday at 11:59 p.m. Unused portions of the prior authorized allotment may not be saved or borrowed from one week for use in another week.

NOTE: Recipients receiving self-directed services should refer to the *Louisiana Department of Health Office of Aging and Adult Services Self-Direction Option Community Choices Waiver Employer Handbook*. (See Appendix B for information on accessing this handbook.)

Adult Day Health Care

Authorization of adult day health care (ADHC) services is issued for the full plan of care year. The service unit is 15 minutes. Depending on the number of units being authorized, the authorization may be issued in two or more PAs. The PA is released for reimbursement after services are provided and documented in the Electronic Visit Verification System using LaSRS.

Caregiver Temporary Support

Authorization for caregiver temporary support service is issued for no more than 30 calendar

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days or 29 overnight stays per plan of care year. Each PA is capped at 14 calendar days or 13 overnight stays and no contiguous PAs are issued.

PAs are released for personal care attendant agencies, ADHC centers and home health agencies after the service has been provided and documented in the LaSRS system.

PAs for assisted living centers, nursing facilities and respite care centers are automatically released at the time of issuance. These providers do not utilize the LaSRS system to document the provision of services.

Monitored In-Home Caregiving Services

Authorization for monitored in-home caregiving services is issued upon receipt of the POC (initial, provisional, or revised). These providers do not utilize the LaSRS system to document the provision of services.

Assistive Devices and Medical Supplies: Personal Emergency Response Systems (PERS) and Telecare

Authorization for assistive devices and medical supplies will be authorized upon receipt of the POC (initial, provisional, or revised). A PA is issued for the one-time installation of PERS and Telecare. An annual PA, comprised of a monthly unit of service, is issued for the monthly monitoring and maintenance. The monthly unit of service is automatically released at the time of issuance. These providers do not utilize the LaSRS system to document the provision of services.

Assistive Devices and Medical Supplies (AD/MS): Durable Medical Equipment (Purchase/Rental/Repair)

Authorization for AD/MS will be issued upon receipt of the POC (initial, provisional, or revised).

When the data contractor receives a POC that indicates a need for AD/MS, a prior authorization is issued to the provider. The prior authorization will be released for payment once the data contractor receives documentation from the support coordinator confirming that the purchase/rental/repair has been received by the recipient. (Refer to Appendix B for the OAAS Assistive Devices and Medical Supplies Form)

Home Delivered Meals

Authorization for home delivered meals is issued according to the POC. The PA must be for a minimum of four meals per week, up to a maximum of 14 meals per week, not to exceed the

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limit of two meals per day. A service unit is one meal. These PAs are simultaneously released upon issuance. These providers do not utilize the LaSRS system to document the provision of services.

Nursing Services

A nursing service assessment and/or ongoing nursing services are authorized upon receipt of the POC (provisional, initial or revised). Authorization is issued for no more than six months of service and is automatically released at the time of issuance.

Maintenance Therapy Services (Physical Therapy, Occupational Therapy, Speech/Language Therapy)

A skilled maintenance therapy assessment and/or ongoing therapy services are authorized upon receipt of the POC (provisional, initial or revised). Authorization is issued for no more than six months of service and is automatically released at the time of issuance.

In the event that reimbursement is received without a PA, the amount paid is subject to recoupment.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

Authorization for these housing support services is made upon receipt of the POC (initial, provisional, or revised). These providers do not utilize the LaSRS system to document the provision of services.

Changing Providers

All requests for changes in services and/or service hours must be made by the recipient or his/her responsible representative.

Changing Support Coordination Agency

A recipient may change to a different support coordination agency after a six month period or at any time for good cause as long as the new agency has not met its maximum number of recipients. Thereafter, a recipient may request a change in support coordination agency every six months.

Good cause is defined as:

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- A recipient moving to another region in the state;
- The recipient and the support coordination agency have unresolved difficulties and mutually agree to a transfer;
- The recipient's health or welfare has been compromised; or
- The support coordination agency has not rendered services in a manner satisfactory to the recipient.

After the recipient has selected and been linked by the data contractor to a new support coordination agency, the new agency must inform the transferring agency and complete the FOC file transfer. The new agency must obtain the case record and authorized signature from the transferring agency.

Upon receipt of the completed form, the transferring agency must have provided copies of the following information to the new agency:

- Most current POC;
- Current assessments on which the POC is based;
- Number of services used in the POC year; and
- Most recent six months of progress notes.

NOTE: The new support coordination agency must bear the cost of copying which cannot exceed the community's competitive copying rate. If the new agency does not receive the information in a timely fashion, the appropriate OAAS regional office should be contacted for assistance.

The transferring support coordination agency shall provide services up to the transfer of records and is eligible to bill for support coordination services for the month in which the dated notification is received (transfer of records) by the receiving agency. In the month the transfer occurs, the receiving agency shall begin services within three days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. Immediately after the transfer of records, the receiving agency must submit the required documentation to the data contractor to obtain prior authorization.

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Prior Authorization for New Support Coordination Agency

A new PA number will be issued to the new support coordination agency with an effective starting date as the first day of the first full calendar month following the date of the transfer of the records. The transferring agency's PA number will expire on the date of the transfer of the records.

The OAAS or its agent will not backdate the new PA period to the first day of the calendar month in which the FOC and transfer of records are completed. If the new support coordination agency receives the records and admits a recipient in the middle of a month, they cannot bill for services until the first day of the next month.

Changing Service Providers

Recipients may change service providers based on the following schedule:

- Personal Assistance Service providers - once every quarter (three months) of the calendar year with the effective date being the beginning of the following quarter of the calendar year; and
- All other service providers (except Transition Services) – once every six months.

Providers may be changed for good cause at any time as approved by the OAAS or its designee.

Good cause is defined as:

- A recipient moving to another region in the state where the current service provider does not provide services;
- The recipient and the service provider have unresolved difficulties and mutually agree to a transfer;
- The recipient's health or welfare has been compromised; or
- The provider has not rendered services in a manner satisfactory to the recipient.

Recipients must contact their support coordinator to change service providers.

The support coordinator will provide the recipient with the current FOC list of service providers in his/her region. Once a new provider has been selected, the support coordinator will ensure the new provider is notified of the request. Depending on the type of services being provided, and

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with written consent from the recipient, both the transferring provider and the receiving provider share responsibility for ensuring the exchange of medical and program information which includes:

- Progress notes from the last six months, or if the recipient has received services from the provider for less than six months, all progress notes from date of admission;
- Written documentation of services provided, including monthly and quarterly progress summaries;
- Current Individualized Service Plan, current assessments upon which the Individualized Service Plan is based, and records tracking recipient's progress towards Individualized Service Plan goals and objectives (if applicable);
- Documentation of the amount of authorized services remaining in the POC including direct service case record documentation; and
- Documentation of exit interview.

The support coordinator will facilitate the transfer of the above referenced information to the receiving service provider and forward copies of the following to the new service provider:

- Most current POC;
- Current assessments on which the POC is based; and
- All other waiver documents necessary for the new service provider to begin providing services.

The new service provider must bear the cost of copying, which cannot exceed the community's competitive copying rate.

Prior Authorization for New Service Providers

The support coordinator will complete a POC revision form that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the POC revision. The transferring agency's PA number will expire on the end date as indicated on the POC revision.

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PROVIDER REQUIREMENTS

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid program, a provider must:

- Meet all of the requirements, including licensure, as established by state laws and rules promulgated by the Louisiana Department of Health (LDH) unless otherwise specified;
- Agree to abide by all rules, regulations, policies and procedures established by the Centers for Medicare and Medicaid Services (CMS), LDH and other state agencies if applicable; and
- Comply with all of the terms and conditions for Medicaid enrollment.

Providers must not have been terminated or actively sanctioned by Medicaid, Medicare or any other health-related programs in Louisiana or any other state. The provider must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in 42 CFR 441.404 (b) and R.S. 40:1203.1 et seq. Providers are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must take all reasonable steps to determine whether applicants for employment have histories indicating involvement in abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

Failure to comply with all regulations may result in any or all of the following: recoupment, sanctions, loss of enrollment, or loss of licensure.

Providers must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment and continued participation as a waiver provider. A Provider Enrollment Packet must be completed by the provider for each provider type and for each LDH administrative region in which the agency or provider will deliver services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number for that provider type.

Support coordination agencies and direct service providers are obligated to report any changes to LDH that could affect the waiver recipient's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

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CCW providers are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the recipient and completing an incident report. The incident report shall be submitted to the Office of Aging and Adult Services (OAAS) or its designee with the specified requirements. (See Appendix B for information on accessing the *OAAS Critical Incident Reporting Policies and Procedures* manual.)

Providers of personal assistance services (PAS), adult day health care, support coordination and caregiver temporary support (except for respite centers, nursing facilities and adult residential care providers) must:

- Participate in all training for prior authorization (PA) and data collection. Initial training is provided at no cost to the provider. Any repeat training must be paid for by the requesting provide; and
- Have available computer equipment software, and internet connectivity necessary to participate in prior authorization, data collection, and Electronic Visit Verification (EVV) as applicable.

Waiver services are to be provided in accordance with the approved plan of care (POC).

Licensure and Specific Provider/Agency Requirements

Providers, or agencies, must meet licensure and/or certification and other additional requirements as outlined in the tables below and in other sections of 7.6:

Support Coordination, Transition Intensive Support Coordination, and Transition Services

Provided by a support coordination agency who:

- | |
|--|
| <ul style="list-style-type: none">• Is certified to provide support coordination services;• Has signed the OAAS Performance Agreement;• Has purchased a Citrix account through the OAAS;• Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training;• Has a brochure that has been approved by OAAS;• Has submitted to the OAAS a completed OAAS' agency contact information form; and• Has enrolled as a Medicaid support coordination agency. |
|--|

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Environmental Accessibility Adaptation (EAA)

An EAA **assessor** must have, either through their own attainments or by contracting with other professionals:

- Clinical expertise - licensed clinical personnel (i.e. Physical Therapist, Occupational Therapist, Rehabilitation Engineer, etc.).

AND

- Construction expertise - meet the requirements of Environmental Accessibility Adaptation Contractor (described below).

AND

- Specialized certification – either the clinical or construction expert must have a specialized certification in Home Modification.

Specialized certification in Home Modification may consist of a supplemental certification through a licensed clinical professional's respective board, or, for the contractor, a comparable certification.

NOTE: Examples of acceptable certifications include, but are not limited to: Certified Aging in Place Specialist (CAPS), Executive Certificate in Home Modifications, Certified Environmental Access Consultant (C.E.A.C).

EAA assessors must submit their enrollment packet to OAAS with documentation as specified in the Medicaid Provider Enrollment Packet (See Checklist in EAA Provider Enrollment Packet).

OAAS will review entire packet and issue a letter of approval - provided that all requirements are met and documentation submitted. Once all requirements have been met, OAAS will forward the packet to Medicaid Provider Enrollment.

Environmental Accessibility Adaptation Contractor Requirements

An Environmental Accessibility Adaptation **Contractor (referred to as "EAA provider")** must:

- Have a general contractor, home improvement, or residential building license,

OR

Be a currently enrolled Louisiana Medicaid DME provider with documentation from the manufacturing company (on that company's letterhead) confirming the DME provider is an authorized distributor of a specific product that attaches to a building, and this provider has been trained on its installation,

AND

- Meet all state and/or local requirements (such as building contractors, plumbers, electricians, or engineers),

NOTE: It is NOT permissible to be enrolled as both an EAA assessor and as an EAA

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provider. EAA providers shall not perform modifications beyond the scope of their state license or manufacturer authorization.

Both EAA assessors and EAA providers must:

- Obtain enrollment as either a Medicaid Environmental Accessibility Adaptation assessor or provider;
- Be listed as a provider of choice on the FOC form;
- Comply with LDH rules and regulations; and
- File claims in accordance with established Medicaid guidelines.

Personal Assistance Service

Provided by a **home health provider** who:

- Is licensed to provide home health services;
- Ensures their direct service workers meet Louisiana's Minimum Licensing Standards as a qualified home health aide for home health agencies; and
- Has enrolled to provide Community Choices Waiver personal assistance services,

OR

Provided by a **personal care attendant (waiver) provider** who:

- Has a Home and Community-Based Services provider license with the Personal Care Attendant Module; and
- Has enrolled as a personal care attendant (waiver) service provider.

Adult Day Health Care (ADHC)

Provided by an **ADHC provider** who:

- Is licensed according to Louisiana Revised Statute 40:2120.47; and
- Has enrolled in Medicaid as an ADHC provider.

NOTE: Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code.

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Caregiver Temporary Support

Provided by a **personal care attendant (waiver) provider** who:

- Has a Home and Community-Based Services provider license with the Personal Care Attendant Module; and
- Has enrolled in Medicaid to provide caregiver temporary support services under the Community Choices Waiver.

OR

By a **home health provider** who:

- Is licensed to provide home health services;
- Is Medicare certified; and
- Has enrolled in Medicaid as a caregiver temporary support provider.

OR

By a **respite center provider** who:

- Is licensed according to Louisiana Revised Statute 40:2101.1; and
- Has enrolled in Medicaid as a caregiver temporary support provider.

OR

By an **adult day health care provider** who:

- Is licensed as an Adult Day Health Care provider according to Louisiana Revised Statutes 40:2120.41-2120.47; and
- Has enrolled in Medicaid as a caregiver temporary support provider.

OR

By a **nursing facility provider** who:

- Is licensed as a Nursing Home according to Louisiana Revised Statute 40:2009.1; and
- Is enrolled in Medicaid as a caregiver temporary support provider.

OR

By an **adult residential care provider** who:

- Is licensed according to Louisiana Revised Statute 40:2166.1; and
- Is enrolled in Medicaid as a caregiver temporary support provider.

CHAPTER 7: COMMUNITY CHOICES WAIVER**SECTION 7.6: PROVIDER REQUIREMENTS****PAGE(S) 16****Assistive Devices and Medical Supplies**Provided by a **Durable Medical Equipment (DME) provider** who:

- Is enrolled to provide DME; and
- Has enrolled in Medicaid as an Assistive Devices and Medical Supplies CCW provider (Provider Type 17);

ORProvided by a **home health agency provider** who:

- Is licensed to provide home health services;
- Is Medicare certified; and
- Has enrolled in Medicaid as an OAAS – Community Choices Waiver assistive devices provider (Provider Type 17).

For **personal emergency response systems (PERS)**, these services are provided by a provider who:

- Is enrolled in Medicaid as a PERS provider; and
- Has furnished verification (copy of letter from the manufacturer written on the manufacturer's letterhead stationary) that the provider is an authorized dealer, supplier or manufacturer of a PERS product.

Home Delivered MealsProvided by a **home delivered meal provider** who:

- Is enrolled in Medicaid as a home delivered meals provider; and
 - **For in-state providers, including their subcontractors** - Has met all Louisiana Office of Public Health's certification permits and inspection requirements for retail food preparation, processing, packaging, storage and distribution;
 - **For out-of-state providers** - Has met all of the United States Department of Agriculture (USDA) food preparation, processing, packaging, storage and out-of-state distribution requirements.

NursingProvided by a **home health provider** who:

- Is licensed to provide home health services;
- Is Medicare certified; and
- Has indicated a subspecialty inclusive of nursing when enrolled in Medicaid to provide Community Choices Waiver nursing services.

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Skilled Maintenance Therapy – Physical Therapy, Occupational Therapy, or Speech/Language TherapyProvided by a **home health provider** who:

- Is licensed to provide home health services;
- Is Medicare certified;
- Has indicated subspecialties inclusive of physical therapy, occupational therapy and/or speech/language when enrolled in Medicaid to provide Community Choices Waiver skilled maintenance therapy services, and
- Uses licensed therapists who have one full year of verifiable experience of working with the elderly.

Housing Transition or Crisis Intervention Services and Housing Stabilization ServicesProvided by a **permanent supportive housing service provider** who:

- Agrees to serve any OAAS waiver recipient who qualifies for permanent supportive housing services;
- Is under contract and enrolled with LDH's Statewide Management Organization for Behavioral Services;
- Has enrolled in Medicaid to provide Community Choices Waiver housing transition or crisis intervention services; and
- Ensures that all agency employees who provide services have either completed the permanent supportive housing training provided by the state of Louisiana Permanent Supportive Housing Program or has at least a year of experience in the Permanent Supportive Housing Program as verified by the director of the Permanent Supportive Housing Program prior to providing services to waiver recipients.

Monitored In-Home Caregiving ServicesProvided by a **monitored in-home caregiving services provider** who:

- Has a Home and Community-Based Services provider license with the Monitored In-Home Caregiving Module
- Is approved by OAAS to provide monitored in-home caregiving services; and
- Has enrolled in Medicaid to provide monitored in-home caregiving services.

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Organized Health Care Delivery System (OHCDS)

Provided by an **OHCDS provider** who:

- Is a qualified and enrolled Medicaid provider who directly renders at least one of the following services offered in the Community Choices Waiver: PAS, home delivered meals, skilled maintenance therapy, nursing, care giver temporary support services, assistive devices and medical supplies, environmental accessibility adaptations, or ADHC;
- Shows the ability (either through its own employees or contracts with other qualified providers) to provide the above listed waiver services; Contracting with ADHC is required only if there is an ADHC provider in the service area;
- Has signed the OAAS Organized Health Care Delivery System Provider Agreement; and
- Has enrolled in Medicaid as an organized health care delivery system provider.

Provider Responsibilities

Providers of CCW services must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable LDH and OAAS rules and policies.

Providers shall not refuse to serve any recipient who chooses their agency, unless there is documentation to support an inability to meet the recipient's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services.

Refusal to serve a recipient must be put in writing by the provider to the support coordinator and the recipient. This written notice must provide a detailed explanation as to why the provider is unable to provide services to the recipient. Upon receipt of this written documentation, the support coordinator is to forward the notice to the OAAS regional office for approval/refusal.

Providers shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to harassment, intimidation or threats against the recipient or members of the recipient's informal network, support coordination staff or employees of LDH.

Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

If the provider proposes involuntary transfer of a recipient, discharge of a recipient or if a

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provider closes in accordance with licensing standards, the following steps must be taken:

- The provider shall provide written notice to the recipient, a family member and/or the responsible representative, if known, and the support coordinator at least 30 calendar days prior to the transfer or the discharge;
- Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the recipient understands;
- A copy of the written discharge/transfer notice shall be put in the recipient's record;
- When the safety or health of recipients or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge;
- The written notice shall include the following:
 - A reason for the transfer or discharge;
 - The effective date of the transfer or discharge;
 - An explanation of a recipient's right to personal and/or third party representation at all stages of the transfer or discharge process;
 - Contact information for the Advocacy Center;
 - Names of provider personnel available to assist the recipient and family in decision making and transfer arrangements;
 - The date, time and place for the discharge planning conference;
 - A statement regarding the recipient's appeal rights;
 - The name of the director, current address and telephone number of the Division of Administrative Law; and
 - A statement regarding the recipient's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

- Holding a transfer or discharge planning conference with the recipient, family, support coordinator, legal representative and advocate, if such is known;
- Developing discharge options that will provide reasonable assurance that the recipient will be transferred or discharge to a setting that can be expected to meet his/her needs;
- Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health,

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behavioral issues, social issues and nutritional status of the recipient; and

- Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

Support Coordination Agencies

Support coordination agencies must meet all of the requirements included in the OAAS support coordination performance agreement, the support coordination standards for participation, the CCW standards for participation and any additional criteria outlined in this manual chapter.

Providers of support coordination must maintain a toll-free telephone line with 24-hour accessibility manned by an answering service. This toll-free number must be given to recipients at intake or at the first meeting with the recipient.

Providers of support coordination must have brochures that provide information about their agency's experience, including the provider's toll-free number and the Office of Aging and Adult Services' (OAAS) toll-free information number.

Providers of support coordination shall furnish information and assistance to recipients in directing and managing their services.

If a recipient elects the option to self-direct his/her PAS, it is the support coordinator's responsibility to review the *Self-Direction Employer Handbook* with the recipient and be available for on-going support and assistance in these decision-making areas and with employer responsibilities.

Environmental Accessibility Adaptation (EAA) Providers

There are two types of EAA providers:

- **EAA Assessors** - responsible for the initial Home Assessment Evaluation (HAE), final inspection, and interim inspections (if needed); and
- **EAA Contractors** (referred to as **EAA providers**) - responsible for completing actual construction and/or structural modification(s) based on the specifications provided by the EAA assessor.

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EAA Assessor

Upon referral from the support coordinator, the applicable professional(s) on staff or under contract must conduct a thorough assessment of the waiver recipient's functional needs and environment to:

- Identify (if applicable) any DME or assistive device/technology that could meet the recipient's needs;
- Determine whether or not there is a need for structural modification/environmental adaptation to the home; and
- Complete a written HAE report to include:
 - a detailed description of the findings;
 - recommendations to satisfy the identified needs of the recipient;
 - justification for any construction/structural modification recommendations rather than alternatives such as DME, assistive technology (AT), etc.;
 - specifications for any recommended construction/structural modifications;
 - cost estimates for each type of recommendation; and
 - signatures of each member of the EAA assessor's team (staff/contractors, etc.) who participated in the evaluation.

In addition, the EAA assessor will be required to:

- Perform inspections as needed throughout the process; and
- Perform a final inspection to ensure that all specifications have been met.

EAA Providers

Upon selection by the recipient, the EAA provider shall:

- Review the written HAE report submitted by the EAA assessor;
- Provide a written bid based on specifications in the EAA assessor's report. The bid must include actual cost with labor and materials listed separately; and
- Complete the adaptation in accordance with the signed agreement/contract.

NOTE: If, for any reason before or during the process, the EAA provider believes it necessary to deviate from the specifications provided in the EAA assessor's written

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report, the EAA provider must first contact the EAA assessor and request a change to the Assessor's HAE report and specifications before proceeding. The EAA assessor may exercise discretion in approving such requests.

- Offer warranty on the service and/or product; and
- Assume responsibility for the costs associated with bringing the work up to standard, including but not limited to materials, labor and costs of any subsequent inspections should the work not be completed according to specifications.

Personal Assistance Service Providers

Every personal assistance service (PAS) provider shall ensure that each recipient who receives service from their agency has a written back-up staffing plan in the event the assigned worker is unable to provide support due to unplanned circumstances or emergencies which may arise during that direct support worker's shift.

In all instances when a direct support worker is unable to provide support due to unplanned circumstances, including emergencies which arise during a direct support worker's shift, the direct support worker must contact the provider and family/recipient immediately. Actions shall then be taken according to the recipient's "Back-Up Staffing Plan."

The following individuals are prohibited from being reimbursed for providing services to a recipient:

- The recipient's spouse;
- The recipient's curator;
- The recipient's tutor;
- The recipient's legal guardian;
- The recipient's responsible representative; or
- The person to whom the recipient has given representative and mandate authority (also known as power of attorney).

Unless an exception is made by the OAAS, recipients are not permitted to receive personal assistance service while living in a home or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the recipient (see the link to

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[“Who Can Be a Direct Support Worker \(DSW\) for PAS & LT-PCS?”](#) in Appendix B).

Family members who provide personal assistance services must meet the same standards for employment as caregivers who are unrelated to the recipient.

PAS providers shall complete and submit the LDH approved cost report(s) to the LDH designated contractor no later than five months after the state fiscal year ends (June 30). (See Appendix A to obtain web address for additional information.)

Back-Up Staffing Plan

PAS providers must:

- Discuss available options for back-up coverage and complete the “Back-Up Staffing Plan” with the recipient or responsible representative. (See Appendix B for information about accessing this form.);
- Obtain all names, telephone numbers of contacts and signatures/verbal agreement of any family/natural supports responsible for emergency coverage;
- Sign and date the form;
- Submit the form to the recipient’s support coordination agency within five business days of being selected as the PAS provider;

NOTE: If the support coordination agency does not receive this form within five business days, the recipient will be instructed to select another provider;

- Assess on an ongoing basis whether the “Back-Up Staffing Plan” is current and being followed according to plan; and
- Collaborate with the recipient or responsible representative, support coordinator, OAAS regional office and protective services when applicable, to assure that all back-up staffing difficulties are resolved appropriately.

Emergency Plan

Support coordination agencies must complete the “Emergency Plan” in a timely manner for each recipient they serve in accordance with OAAS Policy. (See Appendix B for information on accessing this form).

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PAS providers must:

- Collaborate with the recipient's support coordinator as required for completion of the "Emergency Plan"; and
- Sign and return the form to the support coordination agency within five business days of receipt, or give verbal agreement, indicating responsibility accepted for designated tasks on the form.

NOTE: If the support coordination agency does not receive this form within five business days, the recipient will be instructed to select another PAS provider.

If the Emergency Plan is activated, the PAS provider's director bears responsibility for performance of those tasks agreed to in the plan.

Adult Day Health Care Providers

Adult Day Health Care (ADHC) providers are not allowed to impose that recipients attend a minimum number of days per week. A recipient's repeated failure to attend as specified in the Plan of Care may warrant a revision to the Plan of Care, or a possible discharge from the ADHC service and/or the CCW. ADHC providers should notify the recipient's support coordinator when a recipient routinely fails to attend the ADHC as specified.

When an ADHC provider reaches licensed capacity, the OAAS regional office should be notified immediately. The ADHC provider's name will be removed from the ADHC FOC form until the ADHC provider notifies the OAAS regional office that they are able to admit new recipients. (Refer to the ADHC Manual 9.5- Provider Requirements for additional information.)

ADHC providers shall complete the LDH approved cost report and submit the cost report(s) to the LDH designated contractor on or before the last day of September following the close of the cost reporting period. (See Appendix A to obtain web address for additional information.)

Caregiver Temporary Support Service, Assistive Devices and Medical Supply Service, Home Delivered Meal Providers and Monitored In-Home Caregiving Service Providers

Refer to Section 7.1 – Covered Services for information about these services.

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Skilled Maintenance Therapy and Nursing Service Providers

Providers of skilled maintenance therapy and nursing services must:

- Perform an initial evaluation to assess the recipient's need for services;
- Develop an Individualized Service Plan for the provision of skilled maintenance therapy or nursing services which must document the supports that will be provided to the recipient to meet his/her goals based on the recipient's approved Plan of Care; and
- Inform the support coordinator immediately of the provider's inability to provide staff according to the recipient's plan.

Providers of nursing services must also ensure that licensed nurses have received orientation on waiver services and adhere to the requirements in the *OAAS Critical Incident Reporting Policies and Procedures* manual. (See Appendix B for information on accessing this manual.)

Housing Transition or Crisis Intervention Service Providers and Housing Stabilization Service Providers

Providers of housing transition or crisis intervention services and providers of housing stabilization services must comply with the Louisiana Permanent Supportive Housing Program's critical incident reporting requirements and procedures. (See Appendix B for information on accessing the *Permanent Supportive Housing Policies and Procedure Manual*.)

Providers must ensure the housing assessment is current and is performed at least annually. Providers must cooperate and work closely with the recipient's support coordinator to ensure all housing issues are adequately planned for and addressed.

Changes

Changes in the following areas are to be reported to OAAS and the fiscal intermediary's Provider Enrollment Section in writing at least ten days prior to any change:

- Ownership;
- Physical location;
- Mailing address;

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- Telephone number; and
- Account information affecting electronic funds transfer (EFT).

NOTE: Providers who are licensed by LDH's Health Standards Section are also required to report these changes to the Health Standards Section.

The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving recipients. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the provider shall not continue serving recipients until the re-certification process is complete.

When a provider closes or decides to no longer participate in the Medicaid program, a 30-day written advance notice must be sent to all recipients served and their responsible representatives, support coordination agencies, the Health Standards Section (if licensed by same), and the OAAS before discontinuing service.

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SECTION 7.7: RECORD KEEPING PAGE(S) 9

RECORD KEEPING

Providers should refer to the Medicaid Services Manual, Chapter 1 General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping. (<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>)

NOTE: For this section 7.7-Record Keeping, the term “provider” is used to refer to either the HCBS provider or the support coordination agency.

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the enrolled office site in the Louisiana Department of Health’s (LDH) administrative region where the recipient resides. The provider must have sufficient space, facilities and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the recipient served and the provision of services.

A separate record that supports justification for prior authorization and fully documents services for which payments have been made must be maintained on each recipient. The provider must maintain sufficient documentation to enable LDH, or its designee, to verify that prior to payment each charge is due and proper. The provider must make available all records that LDH or its designee, including the recipient’s support coordination agency, finds necessary to determine compliance with any federal or state law, rule or regulation promulgated by LDH.

Retention of Records

The provider or agency must retain administrative, personnel and recipient records for a minimum of six years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six years).

NOTE: Upon provider closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements and copies of the required documents transferred to the new provider.

Confidentiality and Protection of Records

Records, including administrative and recipient, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use.

Employees of the provider must not disclose or knowingly permit the disclosure of any

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information concerning the provider, the recipients or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the recipients or their families.

The information may be released only under the following conditions:

- Court order;
- Recipient's written informed consent for release of information;
- Written consent of the individual to whom the recipient's rights have been devolved when the recipient has been declared legally incompetent; or
- Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

A provider must, upon request, make available information in the case records to the recipient or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the recipient, that information may be withheld from the recipient, except under court order.

The provider may charge a reasonable fee for providing the above records. This fee cannot exceed the community's competitive copying rate.

A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, as long as names are deleted and other similar identifying information is disguised or deleted.

Any electronic communication containing recipient specific identifying information sent by the provider to another agency, or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system.

Recipient records must be located at the enrolled site.

NOTE: Under no circumstances should providers allow staff to take recipient's case records from the facility.

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Review by State and Federal Agencies

Providers must make all administrative, personnel, and recipient records available to LDH or its designee and appropriate state and federal personnel within the specified timeframe given by LDH or its designee. Providers must always safeguard the confidentiality of recipient information.

Recipient Records

Providers must have a separate written record for each recipient served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, support coordination agencies and service providers must have on-going adequate chronological documentation of activities/services offered and provided to the recipients they serve.

Records at the Recipient's Home

Providers must maintain the following documents at the recipient's home:

- A current copy of the recipient's plan of care (POC) and POC Revision (if applicable); and
- Copies of the recipient's service logs for the current prior authorized week. (A prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Saturday at 11:59 p.m.)

Example: If LDH staff or designee goes into the home on a Wednesday, service logs for that day, along with the applicable documentation (if services were performed) from that Sunday, Monday, and Tuesday (the current prior authorized week) are required.

NOTE: A copy of the "Community Choices Waiver (CCW) Personal Assistance Services (PAS) Log" along with instructions for using and completing this form can be found in Appendix B.

LDH or its designee may request additional records from the provider. Records should be made available to the requestor in accordance with LDH policy.

See below for specific information regarding documentation of the following services:

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Support Coordination/Transition Intensive Support Coordination Service Providers	
Monthly Contacts	Complete each calendar month at the time of the monthly monitoring contact according to the Office of Aging and Adult Services (OAAS) documentation and data-entry requirements.
Interim Contacts	Complete at the time of interim activities, according to OAAS documentation and data entry requirements.
Quarterly Contacts	Complete each calendar quarter at the time of the quarterly monitoring contact according to OAAS documentation and data entry requirements.
Case Closure/Transfer	Complete within 14 days of discharge.
Transition Services Providers	
Receipts/Cancelled Checks	Document deposits, set-up fees, or items purchased and reimbursement made to purchaser(s) if outside of support coordination agency.
Transition Services Form (TSF)	Complete to obtain applicable approval for prior authorization.

Environmental Accessibility Adaptation Providers	
Assessment	Completed by assessor with recommendation (either environmental accessibility adaptation job or alternative).
Itemized Bid(s)	Completed by provider when environmental accessibility adaptation job is recommended.

Personal Assistance Service (PAS) Providers	
Service Log	Complete task checklist after each activity has been performed and/or supports have been provided. Page 2 of the service log (progress notes) is to be completed as applicable to reflect observed changes, significant deviations from the POC and other important information about the recipient. (Refer to Appendix B for form/instructions).

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Case Closure/Transfer	Complete within 14 days of discharge.
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Adult Day Health Care Providers

Attendance Log	Complete daily with date and time of arrival and date and time of departure. NOTE: An EVV system generated report satisfies this requirement.
Progress Notes	Complete at least weekly and when there is a change in the recipient's condition or routine.
Progress Summary	Complete at least every 90 days.
Case Closure/Transfer	Complete within 14 days of discharge.

Skilled Maintenance Therapy Providers

Assessment	Complete at time of activity.
Progress Notes	Complete within 10 days of service activity.
Progress Summary	Complete at least every 90 days or as specified in the POC.
Case Closure/Transfer	Complete within 14 days of discharge.

Nursing Providers

Assessment	Complete at time of activity.
Progress Notes	Complete within 10 days of service activity.
Progress Summary	Complete at least every 90 days or as specified in the POC.
Case Closure/Transfer	Complete within 14 days of discharge.

CHAPTER 7: COMMUNITY CHOICES WAIVER**SECTION 7.7: RECORD KEEPING PAGE(S) 9****Home Delivered Meal Providers**

Copy of Invoice	Document delivery of meals to home, including number of meals shipped, date of mailing and price per unit.
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Caregiver Temporary Support Providers

Service Log	Refer to Appendix B for form/instructions.
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Monitored In-Home Caregiving Service Providers

Daily Electronic Notes	Sent via secure web-based exchange documenting delivery of services and overall condition; sent daily
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Assistive Devices and Medical Supply Providers

Copy of Invoice	Document device and/or medical supplies provided including price per unit.
Training on use of Device/Equipment	Document training provided to the recipient and/or representative on the service, use, maintenance, and safety of the device/equipment.
Telecare Monitoring, Maintenance and Contact	Maintain clinical documentation of all service activities, data and all recipient contacts.

Permanent Supportive Housing Providers

*Progress Notes	Complete at the time of activity.
Case Closure/Transfer	Complete within 14 days of discharge.
Housing Needs Assessment	Initially and annually thereafter; revise and update as needed

*See Appendix B for information on accessing the Community Choices Waiver Permanent

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Supportive Housing Progress Note form. Providers are not mandated to use this particular form; however, all elements contained in this form are required to support billing for these services. The use of any Progress Note form other than the one provided in Appendix B must be approved by OAAS or its designee prior to use.

Organization of Records, Record Entries and Corrections

The organization of individual recipient records and location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.

All entries and forms completed by staff in recipient records must be legible, written in ink and include the following:

- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title of the person making the entry;
- The full date of documentation; and
- Reviewed by the supervisor, if required.

Any error made in a recipient's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. **Correction fluid must never be used in a recipient's records.** The provider's office staff may not change any of the documentation entered by the worker.

Service Logs

Service logs document the personal assistance services (PAS) or caregiver temporary support services provided and billed. These service logs are the "paper trail" for services delivered by the worker.

Caregiver temporary support providers are to write "OAAS-CCW Caregiver Temporary Support" on the top of the service log, and document all PAS and non-PAS tasks and comments in the "progress note" space. (See Appendix B for a copy of this form.)

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Service logs contain the following information:

- Name of recipient;
- Name of provider and employee providing the service;
- Date of service contact; and
- Content of service contact.

NOTE: The start and stop time of service contacts, as well as the location where check in/check out occurs, are captured through the use of an Electronic Visit Verification (EVV) System.

A separate service log must be kept for each recipient. Reimbursement is only payable for services documented on the service log. Providers are required to use the standardized weekly service log for documentation of CCW PAS. (*See Appendix B for information on accessing this form and the associated instructions.*)

All portions of the service log must be completed each week. Photocopies of previously completed service logs will not be accepted.

Service logs must be:

- Completed **daily as tasks are performed** (Service logs may not be completed prior to the performance of a task.); and
- Signed and dated by the worker and by the recipient or responsible representative **after the work has been completed at the end of the week.**

Progress notes are located on the second page of the service log and are the means of documenting:

- Observed changes in the recipient's mental and/or medical condition(s), behavior or home situation that may indicate a need for a reassessment and POC, and/or ISP change as applicable;
- Any SIGNIFICANT DEVIATIONS from the POC; and

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- Other information important to ensure continuity of care.

Examples of when to document in a narrative progress note include but are not limited to:

- Provided more assistance than what is indicated in the POC due to the recipient's request or his/her increased need;
- Assistance not provided with a particular task/subtask as indicated in the POC due to recipient's request or his/her lack of need;
- Significant deviation from the POC's flexible scheduled arrival/departure time and/or days on which services are provided.

NOTE: Arriving or departing within 15 minutes of the flexible schedule's time due to everyday factors (e.g. traffic, etc.) is NOT considered a significant deviation from the POC AS LONG AS services are still provided at the same amount, frequency and duration as indicated in the POC.

When progress notes are written, they must:

- Be legible;
- Include the date of the entry;
- Include the name of the person/worker making the entry; and
- Be completed and updated in the record in the time specified.

Each provider's documentation should support justification for prior authorization or payment of services. Services billed must clearly be related to the current approved POC and Individualized Service Plan (ISP), if applicable.

Transfers and Closures

A progress note **MUST** be entered in the recipient's record when a case is transferred or closed.

A discharge summary must also be entered in the recipient's record and detail the recipient's progress prior to a transfer or closure. This summary must be completed within 14 calendar days following a recipient's discharge.

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SECTION 7.8: REIMBURSEMENT**PAGE(S) 3**

REIMBURSEMENT

Reimbursement for Community Choices Waiver services vary based on the type of service being provided. The following services shall be a prospective flat rate for each approved unit of service provided to the recipient. One quarter hour (15 minutes) is the standard unit of service which covers both the service provision and the administrative costs for the following:

- Personal assistance services (not including the “a.m. and p.m.” service delivery model);
- In-home caregiver temporary support services when provided by a personal care services or home health agency;
- Caregiver temporary support services when provided by an adult day health care center;
- Adult day health care services;
- Housing transition or crisis intervention services; and
- Housing stabilization services.

The following services shall be reimbursed at the authorized rate or approved amount of the assessment, inspection, installation/fitting, maintenance, repairs, adaptation, device, equipment, or supply item and when the service has been prior authorized by the plan of care:

- Environmental accessibility adaptations;
- Assistive devices and medical supplies;
- Home delivered meals (not to exceed the maximum limit set by the Office for Aging and Adult Services (OAAS));
- Transition expenses up to a lifetime maximum of \$1500; and
- The assessment performed by the monitored in-home caregiving provider.

The following services shall be reimbursed at a per diem rate:

- Caregiver temporary support services when rendered by the following providers:

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- Assisted living providers;
 - Nursing facility providers; or
 - Respite center providers; and
- Monitored in-home caregiving services (excludes payment for room and board).

The following services shall be reimbursed at an established monthly rate:

- Support coordination;
- Transition intensive support coordination; and
- Monthly monitoring/maintenance for certain assistive devices/technology and medical supplies procedures.

Non-medical transportation is reimbursed per one-way trip at a fee established by OAAS.

Certain nursing and skilled maintenance therapy procedures as well as personal assistance services furnished via the “a.m. and p.m.” delivery method will be reimbursed on a per-visit basis.

Certain environmental accessibility adaptations, nursing, and skilled maintenance therapy procedures will be reimbursed on a per-service basis.

Reimbursement shall not be made for Community Choices Waiver services provided prior to approval of the plan of care and release of prior authorization for the services.

Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. (Refer to Appendix C in this manual chapter for information about procedure code, unit of service and current reimbursement rate.)

The Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR-433.139. Failure by the provider to exhaust all third party payer sources may subject the enrolled agency to recoupment of funds previously paid by Medicaid. Third parties include, but are not limited to: private health insurance, casualty insurance, worker’s compensation, estates, trusts, tort proceeds and Medicare.

The claim submission date cannot precede the date the service was rendered.

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All claims for Community Choices Waiver services, including the Adult Day Health Care (ADHC) service, shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. (Refer to Appendix D of this manual chapter for information about claims filing.)

Span Date Billing

Specific services may be billed as span-dated. Each line on the claim form must represent billing for a single date of service for those services that cannot be span-dated. The following table identifies which services can or cannot be span-dated:

Services that <u>CANNOT</u> be Span-Dated	Services that <u>CAN</u> be Span-Dated
Environmental Accessibility Adaptation	Support Coordination
Caregiver Temporary Support	Personal Assistance Service (PAS)
Personal Emergency Response System, Installation	Personal Emergency Response System, Monthly Service
Telecare Installation	Telecare Monthly Service
Nursing	Monitored In-Home Caregiving Services
Skilled Maintenance Therapy	Home Delivered Meals
Housing Transition or Crisis Intervention Services	
Housing Stabilization Services	
Adult Day Health Care	

Details about when claims can be filed for individual Community Choices Waiver services can be found in Section 7.5 – Service Access and Authorization of this manual chapter.

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SECTION 7.9: PROGRAM OVERSIGHT AND REVIEW**PAGE(S) 6**

PROGRAM OVERSIGHT AND REVIEW

Services offered through the Community Choices Waiver are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal regulations. Oversight is conducted through licensure compliance and program monitoring. The Department of Health and Hospitals' Health Standards Section (HSS) staff conducts on-site reviews to assure state licensure compliance for the providers they license. The Office of Aging and Adult Services (OAAS) staff conducts reviews to monitor compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by individuals served.

On-site review of support coordination providers is conducted by the OAAS regional office staff. Details about the support coordination monitoring process are provided to support coordination providers at the time of enrollment.

Health Standards Section Reviews

The HSS review includes an examination of administrative records, personnel records, and a sample of recipient records. In addition, providers are monitored with respect to:

- Recipient access to needed services identified in the Plan of Care and Individualized Service Plan,
- Quality of assessment and service planning,
- Appropriateness of services provided including content, intensity, frequency and recipient input and satisfaction, and
- Internal quality improvement.

A provider's failure to follow State licensing standards could result in the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

On-Site Reviews

The HSS on-site review with a provider is unannounced to ensure licensure compliance. The on-site review is comprised of the following:

- Administrative Review,
- Personal Record Review,

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- Interviews, and
- Recipient Record Reviews.

Administrative Review

The Administrative Review includes:

- A review of administrative records,
- A review of other agency documentation, and
- Provider agency staff interviews as well as interviews with recipients sampled to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the HSS review questions or findings may result in sanctions or liquidated damages and/or recoupment of payment.

Personnel Record Review

The Personnel Record Review includes:

- A review of personnel files,
- A review of time sheets,
- A review of the current organizational chart, and
- Provider agency staff interviews to ensure that direct service providers, and all supervisors meet the following staff qualifications:
 - Education,
 - Experience,
 - Skills,
 - Knowledge,
 - Employment status,
 - Hours worked,
 - Staff coverage,
 - Supervision documentation, and
 - Other applicable requirements.

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Interviews

As part of the on-site review, the HSS staff will interview:

- A representative sample of the individuals served by each provider agency employee,
- Members of the recipient's network of support, which may include family and friends,
- Service providers, and
- Other members of the recipient's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, and direct service providers and other employees of the direct service provider agency.

This interview process is to assess the overall satisfaction of recipients regarding the provider agency's performance, and provision of services.

Recipient Record Review

Following the interviews, the HSS staff may review the case records of a representative sample of recipients served. The records will be reviewed to ensure that the activities of the provider agency are associated with the appropriate services of intake, ongoing assessment, care planning, and transition/closure.

Recorded documentation is reviewed to ensure that the services reimbursed were:

- Identified in the Plan of Care and Individualized Service Plan (if applicable),
- Provided to the recipient,
- Documented properly, and
- Are appropriate in terms of frequency and intensity.

The HSS staff will review the intake documentation of the Community Choices Waiver recipient's eligibility and procedural safeguards, support coordination and professional

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SECTION 7.9: PROGRAM OVERSIGHT AND REVIEW**PAGE(S) 6**

assessments/reassessment documentation, service plans, service logs, progress notes and other pertinent information in the recipient record.

Report of Review Findings

Upon completion of the on-site review, the HSS staff discusses the preliminary findings of the review in an exit interview with appropriate staff of the provider agency. The HSS staff compiles and analyzes all data collected in the review, and a written report summarizing their review findings and recommended corrective action is sent to the provider agency.

The review report includes:

- Identifying information,
- A statement of compliance with all applicable regulations, or
- Deficiencies requiring corrective action by the provider agency.

The HSS program managers will review the report and assess any sanctions as appropriate.

Corrective Action Report

The provider is required to submit a Plan of Correction to HSS within **10 working days of receipt of the report**.

The plan must address **how each cited deficiency has been corrected and how recurrences will be prevented**. The provider is afforded an opportunity to discuss or challenge the HSS review findings.

Upon receipt of the written Plan of Correction, HSS program managers review the provider's plan to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the HSS program manager responds to the provider requesting immediate resolution of those deficiencies in question.

A follow-up review will be conducted when deficiencies have been found to ensure that the provider has fully implemented the plan of correction. Follow up reviews may be conducted on-site or via evidence review.

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SECTION 7.9: PROGRAM OVERSIGHT AND REVIEW**PAGE(S) 6**

Informal Dispute Resolution (Optional)

In the course of the review process, providers may request an informal hearing with HSS staff. The provider is notified of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits the provider's right to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix A for contact information.)

This request must be made within the time limit given for the corrective action recommended by the HSS.

The provider is notified of time and place where the informal hearing will be held. The provider should bring all supporting documentation that is to be submitted for consideration. Every effort will be made to schedule a hearing at the convenience of the provider.

The HSS program manager convenes the informal hearing and will conduct the hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the review findings. The provider representatives are advised of the date that a written response will be sent and are reminded of the right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Division of Administrative Law.

Fraud and Abuse

When HSS staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section for investigation and sanctions, if necessary. Investigations and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) of the Medicaid Program. DHH has an agreement with the Attorney General's Office which provides for the Attorney General's office to investigate Medicaid fraud. The Office of the Inspector General, Federal Bureau of Investigation (FBI), and postal inspectors also conduct investigations of Medicaid fraud.

Support Coordination Monitoring

The OAAS regional staff conducts annual monitoring of each support coordination provider as a means of monitoring compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by individuals served. The results of the monitoring process are reported to the support coordination provider along with any required follow-up actions and timelines. Recurrent problems are to be addressed by the support

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coordination provider through systemic changes resulting in improvements. Support coordination providers who do not perform all of the required follow-up actions according to the specified timelines, are subject to sanctions.

Support coordination providers are responsible for the following in the monitoring process:

- Offering full cooperation with the OAAS,
- Providing policy and procedure manuals, personnel records, case records, and other documentation, as requested,
- Providing space for documentation review and support coordinator interviews,
- Coordinating with agency support coordinator interviews, and
- Assisting with scheduling recipient interviews.

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INCIDENTS, ACCIDENTS AND COMPLAINTS

Support coordinators and direct service providers are responsible for reasonably ensuring the health and welfare of the recipient and are required to report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion. Reporting shall be in accordance with applicable laws, rules and policies and be made to the appropriate agency named below. Only reporting to a supervisor does not satisfy the legal requirement to report. The supervisor shall be responsible for ensuring that reports or referrals are made in a timely manner to the appropriate agency.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of **all incidents and accidents** involving the recipient. A report of the incident/accident shall be maintained in the recipient's record. The report shall include:

- Date of the incident/accident,
- Circumstances surrounding the incident/accident,
- Description of medical attention required,
- Action taken to correct or prevent incident/accident from occurring again, and
- Name of person completing the report.

Critical Incident Reports

Additional provider responsibilities apply to incidents defined as critical. Critical incidents include, but are not limited to those involving abuse, neglect, exploitation, extortion, major injury, involvement with law enforcement, major illness, elopement/missing, falls and major medication incidents of the recipient. Critical incidents are fully defined in the Office of Aging and Adult Services' (OAAS) *Critical Incident Reporting Policy and Procedures* and include the specific provider responsibilities that must be followed. Non-compliance will result in administrative actions. (See Appendix B for information on obtaining this policy)

Imminent Danger and Serious Harm

Providers shall report all suspected cases of abuse (physical, mental, and/or sexual), neglect,

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exploitation or extortion to the appropriate authorities. In addition, any other circumstances that place the recipient's health and well-being at risk should be reported to Protective Services. Protective Services is responsible for investigating reports and arranging for services to protect vulnerable adults/elders who are at risk of abuse, neglect, exploitation or extortion who live in unlicensed and non-regulated facilities. (See Appendix A for contact information)

If the recipient needs emergency assistance, the worker shall call 911 or the local law enforcement agency before contacting the supervisor.

The responsibilities of the support coordination agency and the direct service provider are outlined in the *OAAS Critical Incident Reporting Policy and Procedures*. (See Appendix B for information on obtaining this policy)

Internal Complaint Policy

Recipients must be able to file a complaint regarding their services without fear of reprisal. The provider shall have a written policy to handle recipient complaints. In order to ensure that the complaints are efficiently handled, the provider shall comply with the following procedures:

- Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint.
- All written complaints should be forwarded to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator.
- The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within five working days**.
- The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the recipient, the responsible representative, the employee, and other interested parties. The provider is encouraged to use all available resources to resolve the complaint internally. The employee's supervisor must be informed of the complaint and the resolution.

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- The provider must inform the recipient, the complainant, and/or the responsible representative in writing **within ten working days** of receipt of the complaint and the results of the internal investigation.
- If the recipient is dissatisfied with the results of the service provider's internal investigation, he/she may continue the complaint resolution process by contacting the Health Standards Section. (See Appendix A for contact information)
- If the recipient is dissatisfied with the results of the support coordination agency's internal investigation, he/she may continue the complaint resolution process by contacting the Office of Aging and Adult Services regional office. (See Appendix A for contact information)

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SUPPORT COORDINATION

Support coordination, also referred to as case management, is an organized system by which a support coordinator assists a recipient to prioritize and define his/her personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Recipients may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies are required to perform the following:

- Intake,
- Assessment,
- Plan of Care Development and Implementation,
- Follow-Up/Monitoring,
- Reassessment, and
- Transition/Closure.

Intake

Intake serves as an entry point into the Community Choices Waiver and is used to gather baseline information to determine the recipient's medical eligibility for waiver services, service needs, appropriateness for services, and desire for support coordination.

Intake Procedures

The applicant must be interviewed to obtain the required demographic information, preferably face-to-face in the applicant's home, within three working days of receipt of the Freedom of Choice (FOC) form from the data management contractor.

The Plan of Care process begins with an initial face-to-face meeting in the applicant's home. The support coordinator requests and gathers demographic, medical, social, educational and psychological information necessary to complete the Plan of Care. Prior authorization to cover services from the beginning date of the Plan of Care will be issued upon approval of the Plan of Care.

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The support coordinator must determine whether the applicant:

- Has a need for immediate support coordination intervention, and
- Is receiving support coordination service or other services from another provider or community resource.

Applicants who are receiving support coordination from another provider must remain with their current provider until approved for the waiver. Requests to change to a different support coordination provider may be made following waiver certification. Refer to “Changing Support Coordination Providers” at the end of this section.

The support coordinator must obtain signed release forms and have the applicant/family sign a standardized intake form that documents the applicant/family:

- Was informed of procedural safeguards,
- Was informed of their rights along with grievance procedures,
- Was advised of their responsibilities,
- Accepted support coordination service,
- Was advised of the right to change support coordination providers, support coordinators, service providers, and
- Was advised that waiver services and support coordination service are an alternative to institutionalization.

If the services in the Community Choices Waiver are not appropriate to meet the applicant’s needs, or if the applicant does not meet the eligibility requirements for waiver services, the applicant will be notified in writing, given appeal rights and directed to other service options, as applicable.

Assessment

Assessment is the process of gathering and integrating informal and formal/professional information relevant to the development of an individualized Plan of Care. The information should be based on, and responsive to, the recipient’s current service needs, desired personal outcomes and functional status. The assessment provides the foundation for support coordination service by defining the recipient’s needs and assisting in the development of the Plan of Care.

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Assessment Process

The person-centered assessment must be conducted by the support coordinator and consist of the following:

- Face-to-face home interviews with the recipient/recipient's family or guardian,
- Direct observation of the recipient,
- Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the recipient, and
- Freedom of choice of all services, support coordination and alternative to institutionalization.

Characteristics and components of the assessment include:

- Identifying information (demographics),
- The use of a standardized instrument for certain targeted populations,
- Personal outcomes identified, defined and prioritized by the recipient,
- Medical/physical information,
- Psycho social/behavioral information,
- Socialization/recreational information including the social environment and relationships that are important to the recipient,
- Patterns of the recipient's everyday life,
- Financial resources,
- Educational/vocational information,
- Housing/physical environment of the recipient,

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- Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes, and
- Information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes, (e.g., input from formal and informal service providers and caregivers as relevant to the personal outcomes).

It is the responsibility of the support coordinator to assist the recipient to arrange any professional/clinical evaluations that are needed to develop strategies for obtaining the services, resources and supports necessary to achieve his/her desired personal outcomes while ensuring recipient choice. The support coordinator must identify, gather and review any information/documents that are relevant to the recipient's needs, interests, strengths, preferences and desired personal outcomes. A signed authorization must be obtained from the recipient/responsible representative to secure appropriate services. A signed authorization for release of information must be obtained and filed in the case record.

Time Frame for Initial Assessment

The initial assessment must begin **within seven calendar days** and be completed **within 30 calendar days** following the referral/linkage.

Ongoing Assessment Procedures

The assessment must be ongoing to reflect changes in the recipient's life and the changing prioritized personal outcomes over time. These changes include strengths, needs, preferences, abilities and the resources of the recipient. If there are significant changes in the recipient's status or needs, the support coordinator must revise the Plan of Care.

Plan of Care Development and Implementation

The Plan of Care is the analysis of gathered information from the recipient/responsible representative and the person-centered assessment process, and is based on the unique personal outcomes identified, defined and prioritized by the recipient.

The Plan of Care is developed through a collaborative process involving the recipient, family, friends or other support systems, the support coordinator and appropriate professionals/service providers and others who know the recipient best.

The Plan of Care serves to:

- Establish direction for all persons involved in providing supports and services for the recipient by describing how the needed supports and services interact to

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form overall strategies that assist the recipient to maintain or achieve the desired personal outcomes.

- Provide a process for ensuring that the paid medical services and other resources are deemed medically necessary and meet the needs of the recipient including health and welfare as determined by the assessment, and that these services and supports are provided in a cost-effective manner.
- Represent a strategy for ensuring that services are appropriate, available, and responsive to the recipient's changing outcomes and needs as updated in the assessment.

The Plan of Care should not be considered a treatment plan of specific clinical interventions that service providers would use to achieve treatment or rehabilitation goals. Instead, the Plan of Care should be considered a “master plan” consisting of a comprehensive summary of information to aid the recipient to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining the desired personal outcomes.

Required Procedures

The Plan of Care must be completed in a face-to-face home visit with the recipient, and members of his/her support network, which may include family members, appropriate professionals, and others, who are well acquainted with the recipient. The POC must be held at a time that is convenient for the recipient.

The Plan of Care must be outcome-oriented, individualized and time limited. The planning process should include tailoring the Plan of Care to the recipient's needs based on the on-going personal outcomes assessment. It must develop mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services. The recipient, support coordinator, members of the recipient's support system, including appropriate professional personnel, must be directly involved in the development of the Plan of Care.

The Plan of Care must assist the recipient to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes, which, involves assisting the recipient to identify specific, realistic needs and choices for the Plan of Care. It must also assist the recipient in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes, including action steps, review dates and individuals who will be responsible for specific steps.

The Plan of Care must incorporate steps that empower and help the recipient to develop independence, growth, and self-management.

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The Plan of Care must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the recipient must be clearly explained. The POC must be approved prior to issuance of any prior authorization.

Required Components

The Plan of Care must incorporate the following required components and shall be prepared by the support coordinator with the recipient, personal representative/family and others, at the request of the recipient:

- The recipient's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed, paid formal services,
- Budget payment mechanism, as applicable,
- Target/resolution dates for the achievement/maintenance of personal outcome,
- Assigned responsibilities,
- Identified preferred formal and informal support/service providers and the specific service arrangements,
- Identified individuals who will assist the support coordinator in planning, building/implementing supports, or direct services,
- Ensured flexibility of frequency, intensity, location, time and method of each service or intervention and is consistent with the Plan of Care and recipient's desired outcomes,
- Change in a waiver service provider(s) can only be requested by the recipient at the end of a 12-month linkage, unless there is "good cause." Any request for a change requires a completion of a Freedom of Choice form. A change in support coordination providers is to be made through the Medicaid data management contractor. A change in direct service providers is to be made through the support coordinator,
- All participants present at the Plan of Care meeting must sign the Plan of Care,
- The Plan of Care must be completed and approved as per Plan of Care instructions,
- The recipient must be informed of his/her right to refuse a Plan of Care after carefully reviewing it.

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Building and Implementing Supports

The implementation of the Plan of Care involves arranging for, building and implementing a continuum of both informal supports and formal/professional services that will contribute to the achievement of the recipient's desired personal outcomes.

Responsibilities of the support coordinator include:

- Building and implementing the supports and services as described in the Plan of Care,
- Assisting the recipient/family to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the Plan of Care,
- Being aware of and providing information to the recipient/family on potential community resources, including formal resources (Food Stamps, Supplemental Security Income, housing, Medicaid, etc.) and informal/natural resources, which may be useful in developing strategies to support the recipient in attaining his or her desired personal outcomes,
- Assisting with problem solving with the recipient, supports, and services providers,
- Assisting the recipient to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet their individual needs,
- Advocating on behalf of the recipient to assist in obtaining benefits, supports or services, e.g., to help establish, expand, maintain and strengthen the recipient's informal and natural support networks by calling and/or visiting recipients, community groups, organizations, or agencies with or on behalf of the recipient,
- Training and supporting the recipient in self-advocacy, e.g., selection of providers and utilization of community resources to achieve and maintain the desired outcomes,
- Overseeing the service providers to ensure the recipient receives appropriate services and outcomes as designed in the Plan of Care,

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- Assisting the recipient to overcome obstacles, recognize potential opportunities and develop creative opportunities, and
- Meeting with the recipient face-to-face in the recipient's home between a six and nine month period and for each annual Plan of Care development, or more often if requested by the recipient/family.

NOTE: Advocacy is defined as assuring that the recipient receives appropriate supports and services of high quality and locating additional services not readily available in the community.

Required Time Frames

- Linkage

The Plan of Care must be completed and received by the OAAS designee or OAAS regional office, as applicable within 35 calendar days following the date of the notification of linkage by the data contractor. All incomplete packages will be returned.
- Changes

Routine changes, such as vacations, must be submitted seven working days prior to the change.
- Emergencies

Emergency changes must be submitted within 24 hours or the next working day following the change.
- Reviews

The Plan of Care must be reviewed between the sixth and ninth month of implementation to ensure that the personal outcomes and support strategies are consistent with the needs of the recipient.

The Plan of Care must be revised annually (and as required) and submitted to the OAAS designee or OAAS regional office no later than 35 days prior to expiration. The Plan of Care may be submitted as early as 90 days prior to Plan of Care expiration.

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Changes in the Plan of Care

If there are significant changes in the support strategies or service providers, the support coordinator must revise the Plan of Care to reflect these changes. A revision request must be submitted for approval/disapproval to the OAAS designee or OAAS regional office, as applicable.

There is flexibility in the Plan of Care for the family to use the services as needed as long as the reimbursement from Medicaid remains within the waiver cap. Therefore, changes will occur only when a service is added or removed from the Plan of Care.

Initiating a Change in the Plan of Care

The recipient/family will contact the support coordinator when a change is required. The support coordinator will call a meeting to complete the Plan of Care revision form. All participants will sign the Plan of Care revision and it will be submitted to the OAAS designee or OAAS regional office, as applicable, for approval/disapproval.

NOTE: The annual expiration date of the Plan of Care should never change.

Documentation

A copy of the approved Plan of Care must be kept in the recipient's home, in the recipient's case record in the support coordination provider and service providers' files. The support coordinator is responsible for providing copies.

A copy of the Plan of Care must be made available to all staff directly involved with the recipient.

Support Coordination Follow-Up/Monitoring

Follow-up/monitoring is the mechanism used by the support coordinator to assure the appropriateness of the Plan of Care. Through follow-up/monitoring activity, the support coordinator not only determines the effectiveness of the Plan of Care in meeting the recipient's needs, but identifies when changes in the recipient's status necessitate a revision in the Plan of Care. The purpose of the follow-up/monitoring contact is to determine:

- If services are being delivered as planned,
- If services are effective and adequate to meet the recipient's needs, and
- Whether the recipient is satisfied with the services.

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The support coordinator and the recipient develop an action plan to monitor and evaluate strategies to ensure continued progress toward the recipient's personal outcomes/goals.

Every calendar month after linkage, the support coordinator must make telephone contact with the recipient to address the following:

- Does the recipient/family feel the outcomes are being met,
- Are the times the services are being provided convenient and satisfactory to the recipient/family,
- Does the recipient/family have any problems or changes that may require additional services,
- Are the providers actually present at the times indicated, and
- Are the provided services adequate and of good quality.

The recipient/family should be informed of the necessity to contact the support coordinator when there are significant changes in the recipient's status or if problems arise with service providers. A change in the recipient's status may require a reassessment.

Notify service providers within three working days of written changes in the Plan of Care.

Meet with the recipient between the sixth and ninth month of implementation of the Plan of Care to determine the effectiveness of the support strategies, and, if necessary, to revise the Plan of Care.

All visits and contacts should be documented in accordance with OAAS documentation and data-entry requirements. (Refer to Section 7.7 of this manual chapter)

Reassessment

Assessment must be ongoing to reflect changes in the recipient's life and changing prioritized personal outcomes over time such as strengths, needs, preferences, abilities and the recipient's resources. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall Plan of Care.

A reassessment may be required when a recipient experiences a change in status, or there is a change in the recipient's family, or the recipient's prioritized needs. A reassessment must be complete **within seven calendar days** of notice of a change in the recipient's status.

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Six-month Review

Between six and nine months after Plan of Care implementation, the support coordinator shall review the Plan of Care with the recipient to determine if the needs of the recipient continue to be adequately addressed.

Annual Reassessment

A completed annual reassessment package must be received by the OAAS designee or OAAS regional office no later than **35 calendar days**, but as early as **90 calendar days** prior to the expiration of the Plan of Care.

Transition/Closure

Transition or closure of support coordination services must occur in response to the request of the recipient, or if the recipient is no longer eligible for services.

Closure Criteria

Criteria for closure of waiver and support coordination services include, but are not limited to the following:

- The recipient requests termination of services,
- Death,
- Permanent relocation of the recipient out of the service area (transfer to another region) or out of state,
- Long term admission to a hospital, institution or nursing facility
- The recipient requires a level of care beyond that which can safely be provided through waiver services,
- 30-day hospitalization/institutional rule (Continuity of Stay Rule), or
- Recipient refuses to comply with support coordination.

Procedures for Transition/Closure

The support coordinator must provide assistance to the recipient and to the receiving provider during a transition to assure a smooth transition process. Transition/closure decisions should be reached with the full participation of the recipient/family. Support coordinators must:

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- Notify the recipient/family immediately if the recipient becomes ineligible for services,
- Complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient methods of negotiating their own service needs,
- Notify the service provider immediately if services are being transitioned or closed,
- Assure the receiving provider, program or support coordinator receives copies of the most current Plan of Care and related documents. (The form 148-W must be completed to reflect the date on the transfer of records and submitted to the OAAS regional office),
- Follow their own policies and procedures regarding intake and closure, and
- Serve as a resource to recipients who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities.

Note: A support coordination provider shall not close a recipient's case that is in the process of an appeal. Only upon receipt of the appeal decision may the case be closed. If an appeal is requested within ten days, the case remains open. If an appeal is not requested within ten days of adverse action notice, the case will be closed.

The provider shall not retaliate in any way against the recipient for terminating services or for transferring to another provider for support coordination services.

Changing Support Coordination Agencies

When a recipient selects a new support coordination provider, the data management contractor will link the recipient to the new support coordination provider. The new support coordination provider must:

- Complete the Freedom of Choice file transfer,
- Obtain the case record and authorized signature, and
- Inform the transferring support coordination provider.

Upon receipt of the completed form, the transferring provider must provide copies of the following information to the receiving support coordination provider:

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- Most current Plan of Care,
- Current assessment on which the Plan of Care is based,
- Number of services used in the calendar year, and
- Most recent six months of progress notes.

The transferring support coordination provider shall provide services up to the transfer of the records and is eligible to bill for support coordination services after the dated notification is received (transfer of records) by the receiving provider. In the month the transfer occurs, the receiving provider shall begin services within three days after the transfer of records, and is eligible to bill for services the first full month after the transfer of records. The receiving provider must submit the required documentation to the OAAS regional office to begin prior authorization immediately after the transfer of records.

Other Support Coordination Responsibilities

The support coordinator is responsible for coordination of the recipient's Community Choices Waiver services in a way that does not duplicate services when the recipient is also receiving other services such as home health, or hospice services.

Incidents, Accidents and Complaints

The support coordination provider must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OAAS and appropriate agency as mandated by law and OAAS policies and procedures. (Refer to Section 7.10 of this manual chapter for additional information)

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SECTION 7.12: ORGANIZED HEALTH CARE DELIVERY SYSTEM**PAGE(S) 1**

ORGANIZED HEALTH CARE DELIVERY SYSTEM

An organized health care delivery system (OHCDS) is an entity with an identifiable component within its mission to provide services to individuals receiving Community Choices Waiver services. The entity must be a qualified and enrolled Medicaid provider and must directly render at least one service offered in the community Choices Waiver. As long as the entity furnishes at least one waiver service itself, it may contract with other qualified providers to furnish the other required waiver service.

Entities that function as an OHCDS must ensure that subcontracted entities meet all of the applicable provider qualification standards for the services they are rendering.

The OHCDS must attest that all provider qualifications are met in accordance with all of the applicable waiver provider qualifications as set forth in this manual chapter.

Prior to enrollment, an OHCDS must show the ability to provide all of the services available in the Community Choices Waiver on December 1, 2012, with the exceptions of:

- Support coordination,
- Transition intensive support coordination,
- Transition services, and
- Adult day health care (if there is no licensed adult day health care provider in the service area).

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APPENDIX A: CONTACT INFORMATION

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CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
OAAS State Office	Provides waiver assistance, clarification of waiver services, receives complaints regarding waiver services	Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031 1-866-758-5035
OAAS Regional Offices	Reviews and provides approval of waiver services, monitors support coordination services and offers providers technical assistance	http://new.dhh.louisiana.gov/index.cfm/directory/category/141
Division of Administrative Law-Health and Hospitals Section	Office to contact to request an appeal hearing	Division of Administrative Law – Health and Hospitals Section P. O. Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 Fax: (225) 219-9823 Phone for oral appeals: (225) 342-5800
Health Standards Section	Office to contact when providers wish to request an informal hearing as the result of a monitoring corrective action report or file a complaint against a provider agency	Health Standards Section Attn: IDR Program Manager P.O. Box 3767 Baton Rouge, LA 70821 1-800-660-0488
Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults living in the community	1-800-898-4910
Myers and Stauffer LC	Information about filing cost reports	http://la.mslc.com/downloads.aspx

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The following documents, forms, links, and manuals are available on the following website addresses:

Form/Document/Website Name	Website Address
Back-Up Staffing Plan	http://new.dhh.louisiana.gov/assets/docs/OAAS/EmergencyPrep/BackupStaffingPlanForm.pdf
Emergency Plan	http://new.dhh.louisiana.gov/assets/docs/OAAS/EmergencyPrep/EmergencyPlanandAgreementForm.pdf
Rights and Responsibilities for Applicants/Participants of Home and Community-Based Services (HCBS) Waiver	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/RightsRespon_Waivers.pdf
Community Choices Waiver (CCW) Service Log	http://www.dhh.louisiana.gov/assets/docs/OAAS/publications/ServiceLogs/CCWServiceLogAndInstructions.pdf
Transition Services Form (TSF)	http://new.dhh.louisiana.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf
OAAS Assistive Devices and Medical Supplies Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Assistive-Devices-and-Medical-Supplies-Form.pdf
Critical Incident Reporting Policies and Procedures	http://dhh.louisiana.gov/assets/docs/OAAS/CIR/CIR-Policy.pdf
Louisiana Department of Health Office of Aging and Adult Services Self-Direction Option Community Choices Waiver Employer Handbook	http://www.dhh.louisiana.gov/assets/docs/OAAS/Manual
Louisiana Department of Health Office of Aging and Adult Services Permanent Supportive Housing Policies and Procedure Manual	http://new.dhh.louisiana.gov/assets/docs/OAAS/PSH/PSHManual.pdf

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APPENDIX B: FORMS/LINKS

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Form/Document/Website Name	Website Address
Community Choices Waiver Permanent Supportive Housing Housing Stabilization Services Housing Transition/Crisis Intervention Services Progress Note Form	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/PSHProgressNote.pdf
Request for Payment/Override Form	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/Request-for-Payment-Override-Form.pdf
Who Can Be A Direct Support Worker (DSW) for PAS and LT-PCS?	http://dhh.louisiana.gov/assets/docs/OAAS/Manuals/dsw_flowchart.pdf
Support Coordination Monitoring Policy and Procedures Manual	http://www.ldh.la.gov/assets/docs/OAAS/Manuals/Support-Coordination-Monitoring-Policy-Procedures.pdf
Waiver Procedures Manual	http://ldh.louisiana.gov/index.cfm/newsroom/detail/2923
Louisiana State Adverse Actions List Search and Office of the Inspector General	https://adverseactions.dhh.la.gov https://exclusions.oig.hhs.gov
Federal System Award Management	https://www.sam.gov/portal/SAM/#1
Medicaid Services Chart	http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

BILLING CODES

Information on procedure codes and the current rates is available at:

lamedicaid.com

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CLAIMS FILING

Hard copy billing of waiver services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Effective for dates of service on or after April 1, 2016, the billing form used by Adult Day Health Care (ADHC) waiver services is being changed from the uniform bill (UB-04) claim form to CMS-1500 (02/12) claim form. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link “HIPAA Information Center, sub-link “5010v of the Electronic Transactions” – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing a CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX D: CLAIMS FILING

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CMS 1500 (02/12) INSTRUCTIONS FOR
HOME AND COMMUNITY – BASED WAIVER SERVICES

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Situational – Enter the recipient's date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE	Leave Blank	
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
9a	Other Insured's Policy or Group Number	<p>Situational – If recipient has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p>	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	

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Locator #	Description	Instructions	Alerts
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabeled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	
21	ICD Indicator Diagnosis or Nature of Illness or Injury	<p>Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required – Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page at (www.lamedicaid.com)</p>

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Locator #	Description	Instructions	Alerts
22	Resubmission Code	<p>Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).</p> <p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.</p>
23	Prior Authorization (PA) Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational.	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</p> <p>If a modifier(s) is required, enter the appropriate modifier in the correct field.</p>	

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Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	Required -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Situational – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is required . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is optional .	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter ‘0’ if the third party did not pay. If TPL does not apply to the claim, leave blank.	

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Locator #	Description	Instructions	Alerts
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional .	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional .	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional . If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

REMINDER: MAKE SURE “WAIVER” IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

Sample forms are on the following pages.

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SAMPLE WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE
(DATES BEFORE 10/1/15)

WAIVER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA		PICA	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>	2. MEDICAID (Medicaid #) <input checked="" type="checkbox"/>	3. TRICARE (ID#DoD#)	4. CHAMPVA (Member ID#)
5. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS		6. PATIENT'S BIRTH DATE (MM DD YY) 07 31 72	
7. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE ()		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? (PLACE / State) YES NO c. OTHER ACCIDENT? YES NO	
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) M SEX F b. OTHER CLAIM ID (Designated by NUCC)		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	
15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. 3510 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER 4123123123		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO		28. TOTAL CHARGE \$ 165.00	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe DATE 4/5/14		32. SERVICE FACILITY LOCATION INFORMATION a. b.	
33. BILLING PROVIDER INFO & PH# (225) 555-4957 Here For You Waiver 200 Main St. Any Town, LA 70000 a. 1239876543 b. 1239876			

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SAMPLE WAIVER CLAIM FORM WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

WAIVER

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE (MM DD YY) 07 31 72 SEX M X F		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		8. RESERVED FOR NUCC USE	
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		9. RESERVED FOR NUCC USE	
CITY STATE ZIP CODE TELEPHONE (include Area Code)		CITY STATE ZIP CODE TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 15. OTHER DATE MM DD YY QUAL 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO \$ CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. G510 B. C. D. E. F. G. H. I. J. K. L. 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER Prior Auth # 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. SPAN (Start/End) I. ID. QUAL. J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234 27. ACCEPT ASSIGNMENT? (For g04, date, see back) X YES NO	
28. TOTAL CHARGE \$ 165.00 29. AMOUNT PAID \$ 165.00 30. BALANCE DUE \$ 165.00		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000	
SIGNED Ima Biller DATE 10/15/15		a. 123967654 b. 1239876	

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ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim.**

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Recipient/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid recipient cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

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The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

Sample forms are on the following pages.

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE
(DATES BEFORE 10/01/15)

WAIVER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX	
JAYCO, TRAVIS		07 31 72 M X F	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED	
CITY STATE		Self Spouse Child Other	
ZIP CODE TELEPHONE (Include Area Code)		7. INSURED'S ADDRESS (No., Street)	
CITY STATE		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
TPL Code if applicable		YES NO	
b. RESERVED FOR NUCC USE		b. AUTO-ACCIDENT? (Place (State))	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? (Place (State))	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED DATE		SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE	
MM DD YY QUAL		MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
17a. NPI		FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9		22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. 3510 B. C. D. E. F. G. H. I. J. K. L.		A 00 4094198765400	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9 CM I. ID. QUAL. J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER	
03 31 14 03 31 14 12 S5125 UN A 75 00 25 NPI		4123123123	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO		28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED Jane Doe DATE 4/9/14		33. BILLING PROVIDER INFO & PH# (225) 555-4957	
a. b.		a. 1239876543 b. 1239876	

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SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)

 **WAIVER**

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA ☐ ☐ ☐ PICA ☐ ☐ ☐

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK/LUNG OTHER (Medicare #) (Medicaid #) (ID#DoD#) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE SEX MM DD YY M X F 07 31 72 M X F		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	
CITY STATE		CITY STATE	
ZIP CODE TELEPHONE (include Area Code)		ZIP CODE TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable		a. EMPLOYMENT? (Current or Previous) YES NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) YES NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? PLACE (State) YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED DATE		11. INSURED'S POLICY GROUP OR FECA NUMBER	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
15. OTHER DATE QUAL MM DD YY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI		20. OUTSIDE LAB? \$ CHARGES YES NO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE ORIGINAL REF. NO. A02 5299198798700	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0		23. PRIOR AUTHORIZATION NUMBER Prior Auth #	
A. G5 10 B. C. D. E. F. G. H. I. J. K. L.		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DATES OF UNITS H. FIRST PAYER I. ID. QUAL J. RENDERING PROVIDER ID. #	
10 08 15 10 08 15 12 S5125 UN A 90 00 30 NPI			
2			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234	
27. ACCEPT ASSIGNMENT? (For gov. date, see back) X YES NO		28. TOTAL CHARGE \$ 90 00	
29. AMOUNT PAID \$ 90 00		30. BALANCE DUE \$ 90 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ima Biller DATE 10/15/15		32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000	
a. 123967654		b. 1239876	

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APPENDIX D: CLAIMS FILING

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SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK (LNG) <input type="checkbox"/> OTHER <input type="checkbox"/>										PICA <input type="checkbox"/>																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)																			
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										9. RESERVED FOR NUCC USE										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										13. OTHER CLAIM ID (Designated by NUCC)																			
14. INSURED'S POLICY OR GROUP NUMBER										15. INSURED'S POLICY OR PROGRAM NAME										16. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																			
17. RESERVED FOR NUCC USE										18. RESERVED FOR NUCC USE										19. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____																			
20. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____										21. OTHER DATE MM DD YY QUAL. _____										22. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE										24. NPI										25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
26. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										27. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____										28. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																			
29. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										30. ICD Ind. _____										31. PRIOR AUTHORIZATION NUMBER _____																			
32. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										33. F. \$ CHARGES G. DAYS OR UNITS H. PRIOR Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										34. 1 2 3 4 5 6																			
35. FEDERAL TAX I.D. NUMBER SBN EIN <input type="checkbox"/> <input type="checkbox"/>										36. PATIENT'S ACCOUNT NO.										37. ACCEPT ASSIGNMENT? For gov. claims, are basic YES <input type="checkbox"/> NO <input type="checkbox"/>										38. TOTAL CHARGE \$ 39. AMOUNT PAID \$ 40. Paid for NUCC Use									
41. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										42. SERVICE FACILITY LOCATION INFORMATION										43. BILLING PROVIDER INFO & PH # ()																			
44. SIGNED _____ DATE _____										45. a. NPI b. _____										46. a. NPI b. _____																			

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CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX E: GLOSSARY

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GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Community Choices Waiver Manual Chapter.

Abuse – The infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his/her health, self-determination, or emotional well-being is endangered. (La. R.S. 15:1503)

Abuse of Medicaid Funds – Inappropriate use of public funds by either providers or recipients, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

Activities of Daily Living (ADL) – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility, and eating. The extent to which a person requires assistance to perform one or more of these activities often is a level of care criterion.

Adult Day Health Care (ADHC) – A medical program model designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community-based direct care center.

Adult Day Health Care Center – Any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more adults with functional impairments who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days per week.

Advocacy – The process of assuring that recipients receive appropriate high quality services and locating additional services needed by recipients which are not readily available in the community.

Allegation of non-compliance – A claim that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a recipient or recipients. (La. R.S. 40:2009.14)

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Allowable Cost – Those expenses incurred by the provider agency which are reasonable in amount and are necessary for the efficient delivery of services.

Appeal – A due process system of procedures which ensures a recipient will be notified of and have an opportunity to contest a Department of Health and Hospitals (DHH) decision.

Applicant – An individual whose written application for Medicaid or DHH funded services has been submitted to DHH but whose eligibility has not yet been determined.

Assessment – One or more processes that are used to obtain information about a person, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person requires waiver services as well as the development of the Plan of Care and an Individualized Service Plan.

Bureau of Health Services Financing (BHSF) – The Bureau within the Department of Health and Hospitals responsible for the administration of the Louisiana Medicaid Program.

Case Management – Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational, housing, and other support services. Activities include assessment, Plan of Care development, service monitoring and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources. Case management is also referred to as support coordination.

Center for Medicare and Medicaid (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Community Choices Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to adults age 65 or older, or between the ages of 21 and 65 with functional impairments, and are disabled according to Medicaid standards.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a recipient or recipients (La. R.S. 40:2009.14).

Continuous Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

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Confidentiality – The process of protecting a recipient’s or an employee’s personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Corrective Action Plan – Written description of action a provider agency plans to take to correct identified deficiencies.

Department of Health and Hospitals (DHH) – The state agency responsible for administering the state’s Medicaid Program and other health and related services including aging and adult services, public health, behavioral health, developmental disabilities, and addictive disorder services.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Direct Care Staff – Unlicensed staff paid to provide personal care and other direct service and support to persons with disabilities or to the elderly to enhance their well-being. This is also referred to as a Direct Service Worker.

Disabled Person - A person with a behavioral, physical, or developmental disability that substantially impairs the person’s ability to provide adequately for his own care or protection.

Eligibility – The determination of whether or not a recipient qualifies to receive services based on meeting established criteria for the target or waiver group set by DHH.

Enrollment – A determination made by DHH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other DHH-funded services. This is also referred to as provider enrollment.

Exploitation – The illegal or improper use or management of an aged person’s or disabled adult’s funds, assets or property, or the use of an aged person’s or disabled adult’s power of attorney or guardianship for one’s own profit or advantage. (La. R.S. 15:1503)

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)

Fiscal Intermediary – The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

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Follow-Up – A core element of support coordination and another term for service monitoring by support coordination.

Formal Services – Another term for professional and paid services.

Good Cause – When the OAAS regional office or its designee approves a recipient's change in support coordination or provider agencies outside the timelines noted in policy if one of the following exists: the recipient is moving to another region in the state where the current provider does not provide services; the recipient and provider have unresolved difficulties and mutually agree to a transfer; the recipient's health or welfare has been compromised; or the provider has not rendered services in a manner satisfactory to the recipient.

Health Standards Section – A section of the Department of Health and Hospitals responsible for the licensure and oversight of certain individual and agency providers of services funded by the DHH.

Home and Community-Based Services Waiver – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirement of an institutional level of care. It provides a collection of services through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services. The number of individuals receiving these services is limited to the number of approved and available waiver opportunities.

Individualized Service Plan – A written agreement developed by a service provider that specifies the long-range goals, short-term objectives, specific strategies or action steps, assignment of responsibility and timeframes for meeting the recipient's personal outcomes as specified in the recipient's approved Plan of Care.

Informal Services – Another term for non-professional and non-paid services provided by family, friends and community/social network.

Institutionalization – The placement of a recipient in an inpatient facility including a hospital, group home for people with developmental disabilities, nursing facility, or psychiatric hospital.

Licensed Practical Nurse (LPN) – an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse.

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Licensure – A determination by the Medicaid Health Standards Section that a service provider agency meets the requirements of State law to provide services or a determination by a professional licensing board that an individual meets the requirements of State law to provide services.

Linkage – Act of connecting a recipient to a specific support coordination or service provider agency.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the DHH. (LA RS 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the recipient's activities of daily living. (La. R.S. 40:2009.14)

Neglect – The failure by a care giver responsible for an adult's care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503)

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within the Department of Health and Hospitals that is responsible for the management and oversight of certain Medicaid home and community-based state plan and waiver programs and protective services for adults ages 18 through 59.

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OAAS Regional Office – One of nine administrative offices within the Office of Aging and Adult Services.

Office of Behavioral Health (OBH) – The office in DHH that is responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (OPH) – The office in DHH responsible for personal and environmental health services.

Office for Citizens with Developmental Disabilities (OCDD) – The office in DHH responsible for services to individuals with developmental disabilities.

Personal Outcome – Result achieved by or for the waiver recipient through the provision of services and supports that make a meaningful difference in the quality of the individual's life.

Person-Centered Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized POC.

Plan of Care (POC) – A written plan developed by the recipient, his/her authorized representative and support coordinator that is based on assessment results and specifies services to be accessed and coordinated by the support coordinator on the recipient's behalf. It includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Primary Care Physician – A physician, currently licensed by the Louisiana State Board of Medical Examiners, who is designated by the recipient or his/her personal representative as responsible for the direction of the recipient's overall medical care.

Progress Notes – Ongoing assessment of the recipient which enables the staff to update the Plan of Care and/or Individualized Service Plan in a timely, effective manner.

Provider/Provider Agency – An agency furnishing Medicaid services under a provider agreement with DHH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other DHH funding source. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other DHH funding source.

Provider Enrollment – Another term for enrollment.

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Reassessment – A core element of services defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and revising the overall Plan of Care and/or Individualized Service Plan.

Recipient – An individual who has been certified for medical benefits by the Medicaid Program. A recipient certified for Medicaid home and community based waiver services may also be referred to as a participant.

Registered Nurse (RN) – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible recipient.

Responsible Representative – An adult who has been designated by the recipient to act on his/her behalf with respect to his/her services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without the recipient's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Self-neglect – The failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)

Sexual Abuse – Abuse of an adult, when any of the following occur: The adult is forced or otherwise coerced by a person into sexual activity or contact; The adult is involuntarily exposed to sexually explicit material, sexually explicit language, or sexual activity or contact; The adult lacks the capacity to consent, and a person engages in sexual activity or contact with that adult.

Support Coordination – See case management.

Support Coordinator – An individual who meets the required qualifications and who is employed by a public or private entity to provide case management (support coordination) services.

Transition – The steps or activities conducted to support the passage of the recipient from existing formal or informal services to the appropriate level of services, including disengagement from all services.

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Trivial Report – A report of an allegation that an incident has occurred to a recipient or recipients that causes no physical or emotional harm and has no potential for causing harm to the recipient or recipients. (La. R.S. 40:2009.14)

Waiver – An optional Medicaid program established under Section 1915 (c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care. See also, Home and Community Based Services Waiver.

Waiver Opportunity – An opportunity for an eligible applicant who meets the requirements for institutional care to receive Title XIX waiver services. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.

CHAPTER 7: COMMUNITY CHOICES WAIVER**APPENDIX F: CONCURRENT SERVICES****PAGE(S) 2****CONCURRENT SERVICES**

Waiver services that are available while a recipient is in a hospital or in a nursing facility are considered concurrent services. Some Community Choices Waiver services are payable when a recipient is in a hospital or nursing facility. All services must be prior approved as indicated in Section 7.1 – Covered Services.

The following Community Choices Waiver services are payable when a recipient who has been receiving Community Choices Waiver services has a temporary stay in a hospital or a nursing facility or when a recipient is transitioning from a nursing facility to the community:

Payable Waiver Services During a Temporary Stay in a Nursing Facility or Hospital

- Support Coordination
- Personal Emergency Response System – Initial Installation
- Personal Emergency Response System – Monthly Maintenance
- Environmental Accessibility Adaptation – Ramp
- Environmental Accessibility Adaptation – Lift
- Environmental Accessibility Adaptation – Bathroom
- Environmental Accessibility Adaptation – Other Adaptations
- Environmental Accessibility Adaptation – Basic Assessment and Approval
- Environmental Accessibility Adaptation – Complex Assessment and Approval
- Physical Therapy Assessment
- Occupational Therapy Evaluation
- Speech Language Hearing Evaluation
- Swallowing Function Evaluation
- Nursing Service Assessment
- Telecare Activity and Sensor Monitoring – Equipment Installation
- Telecare Activity and Sensor Monitoring – Monitoring, Routine Maintenance and Rental
- Assistive Device/Equipment Purchase (not covered under Medicare or Medicaid State Plan)
- Assistive Device/Equipment Rental including Routine Repair and Maintenance (not covered under Medicare or Medicaid State Plan)
- Assistive Device Equipment Repair
- Telecare – Health Status Monitoring – Monitoring, Routine Maintenance and Rental
- Telecare– Medication Dispensing and Monitoring
- Housing Stabilization Services
- Housing Transition or Crisis Intervention Services

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Payable Waiver Services When Transitioning from a Nursing Facility to the Community

- Transition Intensive Support Coordination
- Transition Services
- Environmental Accessibility Adaptation – Ramp
- Environmental Accessibility Adaptation – Lift
- Environmental Accessibility Adaptation – Bathroom
- Environmental Accessibility Adaptation – Other Adaptations
- Environmental Accessibility Adaptation – Basic Assessment and Approval
- Environmental Accessibility Adaptation – Complex Assessment and Approval
- Housing Transition or Crisis Intervention Services