Q-Adult Day Health Care (ADHC) Waiver

Q-110 Attendance Criteria

Adult Day Health Care (ADHC) Waiver participants must attend an ADHC center a minimum of 36 days per calendar quarter unless there are extenuating circumstances that **temporarily** prevent the participant from attending. These circumstances must be approved by the assigned Support Coordinator (SC) on a case-by-case basis with guidance provided by Office of Aging and Adult Services (OAAS).

NOTE: This attendance criteria DOES NOT apply to the ADHC service in the Community Choices Waiver (CCW).

The 36 days per calendar quarter attendance requirement for ADHC Waiver is applicable to the following 4 calendar quarters:

- 1st Quarter: January – March
- 2nd Quarter: April – June
- 3rd Quarter: July – September
- 4th Quarter: October – December

Examples of extenuating circumstances related to the ADHC Waiver attendance requirement include, but are not limited to:

- Applicant/Participant receives dialysis treatment.
- Participant is temporarily admitted to a hospital or rehabilitation facility.
- Participant is temporarily displaced due to housing issues, natural disaster, etc.

  NOTE: Documentation of extenuating circumstances may be requested as deemed necessary by RO.

Admission will be denied if the participant cannot meet the attendance criteria. If certified, the participant may be discharged for failure to meet the attendance criteria.

Q-110.3 Initial ADHC Waiver Participants

SC will:

- Inform the applicant of the attendance requirement criteria AND
- Develop the Plan of Care (POC) according to the attendance criteria.
- If the applicant does not agree to the attendance criteria, the SC will determine if temporary extenuating circumstances exist.

If extenuating circumstances exist and is temporary the SC will:

- Adjust the POC as needed.
- Notify the ADHC provider and the SC supervisor that the applicant has been granted an exception with the reason AND
- Maintain a list of ADHC Waiver participants who have been granted an exception to the attendance criteria.
- Notify Regional Office (RO) of the granted exception.

RO will:

- Document the granted exception within the participant's e-file.

If extenuating circumstances do not exist, the SC will:

- Submit the case to RO for closure.

NOTE: If the SC is unsure if the applicant has an extenuating circumstance the SC will refer the case to RO for guidance.

Q-110.5 Current ADHC Waiver Participants

RO will:

- Pull the ADHC attendance report from the Louisiana Service Reporting System (LaSRS®).
- Review the attendance report for any ADHC participants not meeting the attendance criteria for the quarter.
- Send a list of ADHC participants not meeting the attendance criteria to the Support Coordination Agency (SCA) for review and response of whether the participant has an exception for not attending.

SC will:

- Review the attendance list from RO.
- Contact each ADHC Waiver participant on the attendance list, without a temporary exception, whose attendance record indicates less than the required 36 days per quarter.
- Determine if temporary extenuating circumstances exist; such as, dialysis appointments, psychiatric day program attendance, etc.
- Respond to RO on whether the ADHC participants on the list have an extenuating circumstance preventing attendance.

If temporary extenuating circumstances exist, the SC will:

- Document the exception and approval in the participant's case file. No POC changes are needed.
- Notify the ADHC provider and RO that the participant has been granted a temporary exception and the reason.

- Maintain a list of ADHC Waiver participants who have been granted a temporary exception to the attendance criteria.

RO will:

- Document the granted exception and reason within the participant's e-file.

If extenuating circumstances DO NOT exist AND the participant does not agree to comply with the attendance requirement, the SC will:

- Submit the case to RO for closure and document in the participant's case file.

NOTE: If RO is unsure if the participant has an extenuating circumstance the case can be referred to the OAAS Service Review Panel (SRP) for further guidance.

Q-110.8 Adult Day Health Care (ADHC) Waiver to Community Choices Waiver (CCW) Transition

Participants currently certified in the ADHC waiver who can no longer attend the ADHC center due to a physical decline may request to transition to the CCW.

Support Coordinators (SCs) may submit the requests to the OAAS RO for review and decision by the OAAS SRP.

The SC will submit the ADHC waiver to CCW transition request to the RO and include the following justification:

- How the participant's physical decline warrant a transition to CCW.
- A recent (completed 90 days ago or less) interRAI HC (iHC) assessment demonstrating a decline in the participant's status.
- Why the participant is no longer able to attend the ADHC.
- Interventions the ADHC center implemented to support the participant at the ADHC center.
- Supporting documentation from the ADHC center and other health care providers or professionals, demonstrating the specific need for the request; such as:
    - Statement from a treating medical professional describing why ADHC center is no longer feasible and recommending CCW,
    - Diagnosis of a debilitating progressive disease or immunocompromised state/condition, and/or
    - Statement from the ADHC center regarding their expectation for the participant's attendance.

RO will compile the information and submit a request to the SRP.

SRP will review the submitted request, requesting additional information as needed.

If SRP determines an ADHC to CCW transition is warranted,

SRP will:

- Notify RO of the decision.
- Request a CCW linkage from the Data Management Contractor (DMC).

RO will:

- Notify the SC of the final decision.

If SRP determines an ADHC to CCW transition is not appropriate,

SRP will:

- Notify RO of the decision.

RO will:

- Notify the SC of the final decision.

Q-200 Covered Services for Adult Day Health Care (ADHC) Waiver

Q-200.1 Activity and Sensor Monitoring (ASM)

For Activity and Sensor Monitoring (ASM) definition and policy, refer to Activity and Sensor Monitoring policy document, OAAS-ADM-23-014.

The following are situations, not requirements, where a participant may especially benefit from ASM services:

- Participants that do not also receive Long Term-Personal Care Services (LT-PCS);
- Participants whose Direct Service Provider (DSP) is having trouble securing/providing Direct Service Workers (DSWs);
- Participants that live alone;
- Participants with brittle or lack of natural support; and
- Participants experiencing repeat falls as indicated by Critical Incident Reports (CIRs);
- Participants experiencing pacing or wandering behaviors; and
- Participants who may be alone during evening hours or during the night.

SC will:

- Inform the participant of ASM services.
- Offer Freedom of Choice (FOC) for ASM providers, if the participant chooses this service.

- Include ASM Telecare Installation S5160 (one-time installation fee) and ASM Routine S5161 (monthly) in the Plan of Care (POC)/POC Revision and budget sheet.
- Submit the POC packet to the Support Coordinator (SC) supervisor by following the procedures outlined in this manual.

SC supervisor will:

- Review and approve the POC/POC Revision following the procedures outlined in this manual.
- Submit the approved POC/POC Revision to the DMC, participant, provider(s) and RO following the procedures outlined in this manual.

  Refer to the Activity and Sensor Monitoring Guidance document, OAAS-SC-20-003, for further procedure specific for the applicable ASM provider.

DMC will:

- Issue Prior Authorizations (PAs) after the approved POC/POC Revision is received from the Support Coordination Agency (SCA).

ASM provider will:

- Contact the participant or their representative (legal/responsible) to discuss the ASM components and select the most appropriate components for the participant's own person-centered activity monitoring program.

Q-200.2 Adult Day Health Care (ADHC)

For ADHC definition and policy, refer to Adult Day Health Care under Covered Services in the Louisiana Medicaid Program ADHC Provider Manual.

SC will:

- Inform participant of ADHC.
- Offer Freedom of Choice (FOC) of all ADHC providers if participant chooses this service.
- Include ADHC in the POC and budget sheet.
- Submit the POC packet to the SC supervisor by following the procedures outlined in this manual.

SC supervisor will:

- Review and approve POC following the procedures outlined in this manual.
- Submit the approved POC packet to the DMC, participant, provider(s) and RO following the procedures outlined in this manual.

DMC will:

- Issue Prior Authorizations (PAs) after approved POC is received from SCA.

Q-200.3 Assistive Technology (AT)*

For Assistive Technology (AT) definition and policy, refer to the AT Policy Document (OAAS-ADM-23-005).

AT is a time-limited, non-recurring service which is compromised of the following mandatory components:

- An electronic tablet device with internet capability;
- A screen protector and case; and
- A one-time set-up visit including the delivery of the device, device set-up and in-person education and support.

  NOTE: The participant must have internet service in their home in order to receive the AT service.

The AT device, protector and case may only be purchased by the Support Coordination Agency (SCA). The one-time set-up visit can only be provided by the SCA. Authorization for the AT service is limited to a one-time lifetime purchase amount of up to $250 for the AT device (including screen protector, and case) and $50 for the AT procurement/set-up visit. Ongoing support and device repair or replacement is NOT included in this service. **Only the SCA can bill and be reimbursed for these services.**

The identified need and how the needs will be addressed with the AT must be included in the POC or POC revision.

SC will:

- Inform the participant of the AT service.
  - Discuss assistive technology product options.
    - Refer to the Have You Heard About Assistive Technology document, OAAS-R-23-003, for specific device and case product options.
  - Discuss the internet access requirement.

- Verify that there is current internet service in the participant's residence through verbal affirmation from the participant/representative (responsible or legal).
    - If there is not currently internet service in the participant's residence, provide referrals to low-cost internet options and offer assistance in applying for the service.
    - Proceed with the AT procedure once internet access is established and verified.

- Determine if the requested item(s) are necessary and approvable purchases within the AT service, and if so,
- Obtain the cost for the device, screen protector and protective case that meet the specifications outlined in in the AT Policy document, OAAS-ADM-23-005 and in the Have You Heard About Assistive Technology document, OAAS-R-23-003.

  NOTE: The total cost for the device, screen protector and protective case cannot exceed $250.

- Identify natural support that can assist the participant with device set-up and simple instruction
- Complete the Assistive Technology Services form, OAAS-PF-23-002.
    - Complete Section I. Assistive Technology Items to be billed by the SCA.
- Include Assistive Technology Purchase (tablet, case, screen protector) (T2035) and Procurement Fee (delivery & set-up) (T2025/SE) on the POC/ POC revision budget page.

  NOTE: There is a one-time lifetime cap for the AT service. AT service costs are excluded from the participant's POC budget allotment.

- Include the AT identified need and how the needs will be addressed with the AT service in the CAPS section of the POC/POC revision.

- Submit the POC packet and Assistive Technology Form, to the Support Coordinator Supervisor (SCS) for approval following the procedures outlined in this manual.

SCS will:

- Review and pre-approve the Assistive Technology Form.
- Review and approve the POC/POC revision following the procedures outlined in this manual.
- Submit the approved POC packet and Assistive Technology Form to the DMC and RO.
- Submit the approved POC packet to the participant following the procedures outlined in this manual.

SC will:

- Purchase the items as listed on the Assistive Technology Form.
- Contact the participant/RR to schedule the delivery and set-up visit.
    - Verify with the participant/representative (legal or responsible) that there is currently active internet service at the participant's residence and that natural support will be available to assist with device set-up.
- Deliver the items to the participant.
    - If the participant is not able to complete the device set-up or has no identified natural support to assist, the SC will:
        - Turn on the device to verify functioning and connect the device to the participant's internet source.
        - Show the participant how to charge the device.
        - Provide a simple overview of the device including downloading an email application, or other applications, (if the participant chooses) and how to access the device's internet browser and use the search bar.

- Refer to the AT Delivery and Set-Up One Page Guide, OAAS-SC-23-010

  NOTE: Ongoing device support or troubleshooting is NOT required.

- If the participant can complete device set-up or has identified natural support to assist, they are responsible for completing the device set-up.

  - The SC will follow-up to ensure that device set-up was completed and the device is operable.

- Obtain the participant/responsible representative's signature on Section III. Participant/Responsible Representative Acknowledgement, verifying the receipt of the device, case, screen protector and set-up.

- Collect and submit the original receipts along with the Assistive Technology Form to SCS for verification and final approval.

If there are any discrepancies between the total listed on the pre-approved Assistive Technology Form and the actual cost, the SC will:

- Submit a revised POC budget worksheet to SCS reflecting the actual total cost.

SCS will:

- Utilize the pre-approved Assistive Technology Form to ensure that only the item(s) listed are reimbursed.

- Complete Section IV. of the Assistive Technology Form for final approval.

- Submit the approved Assistive Technology Form to the DMC and RO.

DMC will:

- Issue PAs after the approved POC is received from the SCA.

SCA will:

- Bill the Medicaid fiscal intermediary contractor for this service within 60 calendar days from the purchase date.
- Maintain documentation including each participant's Assistive Technology Form with original receipts.

***Assistive Technology services are available from April 1, 2023 until American Rescue Plan Act of 2021 (ARPA) funds are exhausted.**

Q-200.4 ADHC Health Status Monitoring (HSM)

For Adult Day Health Care Health Status Monitoring (ADHC HSM) definition and policy, refer to Adult Day Health Care (ADHC) Health Status Monitoring (HSM) policy, OAAS-ADM-23-013.

The ADHC HSM service can only be provided by the ADHC Waiver participant's ADHC provider. The ADHC provider may contact the ADHC participant via telephone on scheduled ADHC attendance days when the participant does not attend as scheduled on their approved Plan of Care (POC).

The ADHC provider will document details of the contact in the progress notes of the participant's record and provide follow-up on any identified needs discovered during the contact.

NOTE: ADHC providers may ONLY provide ADHC HSM on days when the ADHC Waiver participant is scheduled to attend the ADHC center, per the approved Plan of Care and DOES NOT attend the ADHC center on that day(s).

The ADHC HSM service is not added to the participant's POC. The Data Management Contractor (DMC) will release Post Authorizations (PAs) for the service per the ADHC provider's entry of the contact in the Electronic Visit Verification (EVV) system, Louisiana Services Reporting System (LaSRS®).

Q-200.5 Home Delivered Meals

For Home Delivered Meals definition and policy, refer to Home Delivered Meals policy, OAAS-ADM-23-007.

Meals provided through the home-delivered meal service cannot overlap with the meals provided while the participant is attending the ADHC center. Meals must be provided by an enrolled Medicaid HDM provider.

NOTE: The ADHC provider can provide HDMs, but must be enrolled as an HDM provider and then provide HDMs as a HDM provider.

SC will:

- Inform participant of Home Delivered Meals (HDMs) services.
- Offer FOC of HDM providers if the participant chooses this service.
- Include HDMs in the POC and budget sheet.
    - HDMs are limited to 2 meals per day.
- Ensure the HDM service delivery does not overlap with the meals provided on the participant's scheduled ADHC center attendance days.
    - HDM providers CANNOT bill for HDMs on the days the ADHC waiver participant attends the ADHC center in person.
- Submit the POC packet to the SC supervisor by following the procedures outlined in this manual.

SC supervisor will:

- Review and approve the POC following the procedures outlined in this manual.
- Submit the approved POC packet (including the budget worksheet) to the DMC, participant, RO and provider(s) following the procedures outlined in this manual.

  NOTE: The approved POC packet can be submitted by any SCA representative.

DMC will:

- Issue PAs after approved POC is received from the SCA.

NOTE: The SC is responsible for informing the home delivered meal provider of any changes in meal delivery within 24 hours of notification. Examples of this include, but are not limited to, participant hospitalization, admission to nursing facility, death, etc.

Q-200.6 Long Term-Personal Care Services (LT-PCS) Out-of-State Delivery

LT-PCS is traditionally provided in the participant's home but may be provided outside of the home if it allows the individual to participate in life activities pertaining to the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as specified the POC.

Example: The participant is receiving medical treatment from a provider located out of state. The Direct Service Worker (DSW) is needed to accompany the participant to assist with ADLs.

The provision of LT-PCS outside of the borders of Louisiana requires written approval of OAAS or its designee, detailing the specifics of the request and justifying the need of the service delivery out of state. LT-PCS delivery location is regularly monitored and audited by OAAS and its contractors.

NOTE: Out-of-state LT-PCS delivery without documented SC approval will be referred to the Louisiana Department of Health (LDH) Program Integrity Section for fraud review.

If the out-of-state service delivery is a regular occurrence and is known at the time of the POC development, the SC should include the details of the out-of-state service delivery in the approved POC.

The SC will:

- Include details and justification of the out-of-state LT-PCS delivery in the POC.

- Notate the out-of-state LT-PCS delivery on the POC.

For non-reoccurring out-of-state service delivery, not included in the POC, the Direct Service Provider (DSP) must request approval for delivery of LT-PCS outside of the state of Louisiana at least 24 hours prior to the anticipated travel.

The DSP will:

Submit the request for out of state LT-PCS delivery with justification to the SC at least 24 hours prior to the anticipated travel.

The SC will:

- Review the out-of-state LT-PCS delivery request and justification.
- Include details of the out-of-state LT-PCS delivery request and justification in the Support Coordination Documentation (SCD).
- Once approved, detail the approval in the SCD.
- Notify the DSP of the approval and document the notification on the SCD.
- Notify RO of the approval and document the notification on the SCD.

NOTE: Failure of the participant, DSP or SC to follow the process and document as detailed above may result in a fraud referral to LDH Medicaid Program Integrity.

Q-200.65 Personal Emergency Response System (PERS)

For Personal Emergency Response System (PERS) definition and policy, refer to PERS Policy, OAAS-ADM-24-001.

PERS is appropriate for participants that are cognitively and/or physically able to operate the device and are alone for significant periods of time.

SC will:

- Inform the participant of the PERS service.

- Offer Freedom of Choice (FOC) for PERS providers, if the participant chooses this service.
- Include PERS Installation, S5160 NU (one-time installation fee) and PERS Routine S5161 FQ (monthly service fee) in the Plan of Care (POC)/POC Revision and budget sheet.
- Submit the POC packet to the Support Coordinator (SC) supervisor by following the procedures outlined in this manual.

SC supervisor will:

- Review and approve the POC/POC Revision following the procedures outlined in this manual.
- Submit the approved POC/POC Revision to the DMC, participant, provider(s) and RO following the procedures outlined in this manual.

DMC will:

- Issue Prior Authorizations (PAs) after the approved POC/POC Revision is received from the Support Coordination Agency (SCA).

PERS provider will:

- Contact the participant or their representative (legal/responsible) to schedule and complete the PERS installation.

PERS provider will complete maintenance checks on the system monthly to ensure it is functioning properly.

The SC will check the PERS unit once every quarter by the SC during the required home visit/virtual quarterly contact.

NOTE: A participant cannot simultaneously receive Activity and Sensor Monitoring (ASM) services and PERS services.

Q-200.7 Support Coordination

For Support Coordination definition and policy, refer to Support Coordination Section under Covered Services in the Louisiana Medicaid Program ADHC Provider Manual.

SC will:

- Inform participant of support coordination services.
- Include Support Coordination service in the POC.
- Submit the POC packet to the SC supervisor by following the procedures outlined in this manual.

SC supervisor will:

- Review and approve POCs to the DMC following the procedures outlined in this manual.

DMC will:

- Issue Prior Authorizations (PAs).
- Not release PAs for the previous month unless quarterly requirements are met.

Q-200.7.1 Contact Requirements

Adult Day Health Care (ADHC) Waiver With or Without In-Home Services

SC will complete monthly (at minimum) phone contacts with the participant or representative (responsible or legal). A monthly contact is required in the month in which a quarterly (virtual or in-person) was completed, can be

simultaneous and should be coded on the Support Coordination Documentation (SCD).

The SC will complete at least 3 in-person visits with the participant/their representative per Plan of Care (POC) year:

- An in-person iHC assessment visit;
- An in-person quarterly visit at the participant's residence; and
- An in-person quarterly visit at the participant's ADHC center.
    - If the participant has an approved extenuating circumstance for ADHC non-attendance and has not attended the ADHC during the quarter, this visit may be conducted at the participant's residence.

NOTE: All iHC assessments must be completed in person. Refer to Section H-Assessments/Reassessments.

SC will complete 4 required quarterly visits per POC year. A quarterly contact is required in the quarter in which an iHC assessment/annual visit was completed, can be simultaneous and should be coded on the Support Coordination Documentation (SCD). The SC must complete an in-person quarterly visit at the ADHC and an in-person quarterly visit at the participant's residence. Remaining quarterly visits may be conducted virtually following Section V-Virtual Visits of this manual and the OAAS Telehealth/Virtual Contact Policy, OAAS-ADM-23-011.

Virtual quarterly visits cannot be held consecutively. Refer to Section V-Virtual Visits of this manual.

The Annual POC meeting may be conducted virtually; however, all POC documents and forms must be signed by the participant/their representative (responsible or legal), the SC and the waiver service providers. The actual POC signature and budget pages must be signed with a physical signature. Methods for obtaining acceptable physical signatures include: in person, by fax or scanned/emailed securely. Physical signatures or verbal agreements are acceptable on the OAAS Back-Up Staffing Plan, OAAS-PF-10-015 and the OAAS Emergency Plan, OAAS-PF-09-004.

NOTE: Month is defined as a calendar month.

Quarter is defined as three (3) calendar months:

- **1st Quarter: January – March**
- **2nd Quarter: April – June**
- **3rd Quarter: July – September**
- **4th Quarter: October - December**

Q-200.8 Transition Intensive Support Coordination (TISC)

For TISC definition and policy, refer to Transition Intensive Support Coordination Section under Covered Services in the Louisiana Medicaid Program ADHC Provider Manual.

SC will:

- Inform participant of transition intensive support coordination services.
- Make monthly telephone calls directly with individual or in-person visits with individual in Nursing Facility (NF), if unable to talk directly with individual via telephone.

NOTE: If the individual lacks capacity to express their wishes or if interdicted, contact must be made with the appropriate representative, legal or responsible.

- Include TISC service in the POC up to 6 months prior to transitioning from the NF.
- Visit individual's prospective residence, identifying any transition barriers.
- Submit the POC packet to the SC supervisor by following the procedures outlined in this manual.

SC supervisor will:

- Review, approve and submit the POC to the DMC following the procedures outlined in this manual.

DMC will:

- Issue PAs.

Q-200.8.1 Transition Intensive Support Coordination (TISC) Contact Requirements

ADHC Waiver Transition Intensive Support Coordination: Monthly phone contacts with the individual and/or legally responsible representative until the individual transitions home. If the SC is unable to make contact by phone, an in-person visit with the individual and/or legal or responsible representative must be conducted.

If the individual is unable to transition out of the NF after 6 months, the SCs will follow up with monthly contacts (phone or in-person) until the individual transitions into the community.

NOTE: Month is defined as a calendar month.

Quarter is defined as three (3) calendar months:

- **1st Quarter: January – March**
- **2nd Quarter: April – June**
- **3rd Quarter: July – September**
- **4th Quarter: October - December**

Q-200.9 Transition Service

For Transition Service definition and policy, refer to Transition Service section under covered services in the Louisiana Medicaid Program ADHC Provider Manual.

Transition Services essential to the individual's transition into community must be purchased and in place prior to Nursing Facility discharge.

Non-essential items can be obtained after transition has occurred.

SC will:

- Inform participant of Transition Services.
- Determine if Transition Services are needed and if so, identify payer(s) of those services.
- Complete the Transition Service Form (TSF).
- Include transition service in the POC and budget sheet.
- Submit the POC packet and TSF to the SC supervisor following the procedures outlined in this manual.

NOTE: Purchases cannot be made until the TSF has been pre-approved. (Purchase date on the receipt(s) cannot precede the TSF pre-approval date.)

SC supervisor will:

- Review and pre-approve TSF.
- Review and approve POC following the procedures outlined in this manual.
- Submit approved POC packet to the DMC, participant, provider(s) and RO following the procedures outlined in this manual.

SC will:

- Assist with obtaining items identified on TSF.
- Verify that items purchased are listed on the TSF.

- Collect and submit original receipts to SC supervisor for verification.

- Submit a revised budget worksheet to SC supervisor reflecting the actual cost, if there are any discrepancies between the estimated and actual TS costs.

NOTE: On the day of discharge from NF, the SC will conduct an in-person visit at participant's new residence to verify purchased items and document findings.

SC supervisor will:

- Utilize the pre-approved TSF to ensure that only the item(s)/service(s) listed are reimbursed to the designated purchaser. The designated purchaser can be the individual, their responsible representative, DSP, SCA, or any other source. However, the SCA is the only source that can actually bill for Transition Services.

- Review the TSF for final approval.

- Send the TSF to the DMC and RO.

NOTE: Any items not listed on the original approved TSF will not be reimbursed on this TSF. If additional items are discovered within the established timelines, a new TSF and POC Revision must be completed.

DMC will:

- Issue PAs after approved POC is received from SCA.

SC will:

- Bill the Medicaid fiscal intermediary contractor for this service within 60 calendar days from actual move date.

- Reimburse the designated purchaser within 10 calendar days of receipt of reimbursement.

- Maintain documentation including each individual's TSF with original receipts and copies of cancelled checks, as record of payment to the designated purchaser(s).

NOTE: If the individual is not approved for waiver services and/or does not transition, but transition service items were purchased, SCA will notify RO which will contact State Office (SO) to allow for possible reimbursement.

In the event that additional needs are identified after the original TSF request was approved, the SC must submit a new TSF within 90 calendar days after the individual's actual move date. The same procedure outlined above will be followed for any additional needs.

If it is determined that the individual has additional needs that were not identified, or billing was not able to occur, within the above established timelines, RO must notify OAAS SO to review for exception.