

Office for Citizens with Developmental Disabilities (OCDD)

Quarterly Provider Meeting Updates

December 16, 2025

The OCDD quarterly provider meeting was held on Tuesday, December 16, 2025. The following topics were discussed. Janae Burr opened the meeting reminding providers that agenda items are requested in advance, and the discussions today will address the agenda items submitted.

ACT 421 – CMO and 90L’s – Brandi Croft – OCDD State Office

Ms. Croft presented the following information regarding ACT 421-CMO (ACT 421) and 90L’s

The initial linkage of an individual to the Children’s Choice Waiver may result in a pending enrollment for ACT 421-CMO services. A child may be approved for Medicaid through ACT 421 until they are certified into the waiver. When the pending enrollment to ACT 421 starts, a 90L is required for the enrollment to be completed. The OCDD State Office will check the OCDD database, LaSRS, to see if a 90L has been uploaded to the “working plan of care” in LaSRS. If not, the OCDD State Office will reach out to the Support Coordinator to see if the 90L has been completed to avoid a duplicate 90L. Once the 90L is received by the OCDD State Office, the Local Governing Entity will complete a Level of Care assessment, and the LDH Medical Eligibility Determination Team (MEDT) will complete the disability determination review which may expedite the overall certification process for the Children’s Choice

Support Coordinators are asked to respond to any request for a 90L by the ACT 421 state office staff.

Adult Protective Services (APS) Complaints Timeline – Wanda Warner, Health Standards Section (HSS)

Ms. Wanda Warner presented information regarding APS complaints.

State Office (SO) Home and Community Based Services (HCBS) Complaint Desk (Complaint Desk) –

The allegation is initially received by the State Office HCBS Complaint Desk. The SO HCBS Complaint Desk will determine if non-compliance has occurred. If so, an intake will be initiated as a 2 day or 30 investigation based on the egregiousness of the allegations. If the allegation is egregious, the SO HCBS Complaint Desk will send a referral to the DSW registry desk prior to sending to the Health Standards Section (HSS) Field Office for investigation.

HSS Field Office (FO) –

The surveyors at the HSS FO will review the allegation and will go to the facility within the “2 days” or “30 days” based on triage of the SO HCBS Complaint Desk. During the investigation, surveyors will either substantiate or not substantiate the allegation. Once the investigation is complete, the survey packet is sent back to SO HCBS Desk for review and referral.

The SO HCBS Complaint Desk will review the package and then send a referral to the DSW Registry, Program Integrity, or Attorney General as required. At this time or prior to initiating an intake, if there are allegations of physical or sexual abuse law enforcement is notified.

Direct Service Worker (DSW) Due Process

DSWs who have an allegation of abuse/neglect/exploitation (A/N/E) have due process prior to their name being placed on the registry. Due process includes an informal dispute resolution (IDR) as well as a hearing by the Administrative Law Judge (ALJ). The individual will not be placed on the registry until these proceedings are final. There are variables that affect due process, so a timeline cannot be provided.

Providers are responsible for continuing to ensure the beneficiary is protected from harm. Providers should reach out to Health Standards if they need the status on a specific A/N/E case. If Health Standards does not have the status, then no additional information can be provided.

Q&A –

- What if the beneficiary is abusing the DSW? If staff is put in any type of jeopardy or there are issues with the beneficiary, HSS will get with the program offices to discuss. Neither the staff nor beneficiary should be in any jeopardy.
- What is the process if the complaint is naming a family member? The process does not change even if it is a family member.
- What happens if you pass the 30 day mark and have not heard back from APS? HSS does not hear back from APS. The complaint is triaged by the complaint desk who determines if it is a 2 day complaint (egregious) or a 30 day complaint. Then it goes to the HSS Field Office and a surveyor will investigate the complaint. Providers should read the HCBS Licensing Rule (part 48, Chapter 50) and the DSW Registry Rule (part 48, Chapter 92) to know what they need to do.
- What if an individual continues to make false allegations against a worker when the individual becomes upset? HSS will have the program office get involved to discuss the waiver beneficiary and usually come to a resolution on what we need to do between the program office and health standards.
- What happens if a DSW is removed from an agency for abuse and neglect allegations but has not been charge and the DSW goes to another agency and is hired? Providers are required to check the Louisiana Adverse Actions list and the OIG Exclusions list monthly. Providers need to retain proof of the review of these lists.
- Should an agency be cited if the beneficiary denies abuse and did not report exploitation when asked, but then later tells HSS that the exploitation happened? All allegations are investigated and the results of the investigation will determine if the agency is cited.
- Is HSS is investigating an individual or a facility? HSS investigates Home and Community Based providers.

Critical Incident Reports (CIR) – Alyssa Matthews, OCDD Program Manager within Quality Section

Ms. Alyssa Matthews presented information regarding visual workflows for the critical incident reporting process for both Direct Support Provider Agencies and Support Coordination Agencies.

Visual Workflows for Direct Support Provider Agencies (DSPAs) and Support Coordination Agencies (SCAs) staff for critical incident reporting.

Workflows were created from the Operational Instruction for Critical Incident Reporting. These guides give the DSPAs and SCAs steps for the critical incident reporting process. OCDD Quality section trains on these specific responsibilities quarterly.

To access the workflows, go to your Google search page and enter “OCDD Critical Incident Report”. Select the result titled “Critical Incident Reporting for OCDD” at the ldh.la.gov webpage. OCDD recommends that providers download these workflows and save on your desktop.

Once you get to the OCDD Critical Incident Reporting page on “ldh.la.gov”, scroll to the bottom of the page and go to “Resources for Waiver Participants, Families and SIMS Users”. When you click the dropdown, you will see a section titled “Visual Workflows”. There are four. Ms. Matthews reviewed the Direct Service Provider Agency (DSPA) and Support Coordination Agency (SCA) key responsibilities.

Each visual workflow has two pages; the first page is if there *is no suspected abuse, neglect, exploitation, or extortion* and the second page of the visual workflow is if there *is suspected abuse, neglect, exploitation, or extortion*.

Ms. Matthews went through each of the visual workflows. Providers and support coordination agencies need to review these workflows and ensure their staff are completing all steps. Ms. Matthews highlighted the following that have the most common issues:

DSPA / SCA Workflow

- The DSPA responsibilities are for traditional providers. If a DSW who works for a DSPA is also a family member of the person supported, they are responsible for following the same reporting requirements as any other DSW that works with the individual. DSWs who are family members and work with a provider agency must follow all of the same rules as DSWs who are not family members.
 - “CIR – During paid hours – Family is paid staff” = DSPA discovers CIR = See [Direct Service Provider Agency \(DSPA\) Key Responsibilities in Critical Incident Reporting](#) Family is in role of DSP and must complete DSPA key responsibilities in critical incident reporting
 - “CIR – During paid hours – Non-Family is paid staff” = DSPA discovers CIR = See [Direct Service Provider Agency \(DSPA\) Key Responsibilities in Critical Incident Reporting](#)
 - “CIR During Non-Paid Hours” = CIR occurs with family and no staff on duty = See [Waiver Participant and Family Key Responsibilities in Critical Incident Reporting](#) Family is in role of family and must complete family key responsibilities in critical incident reporting
- Ensure the beneficiaries first and last name, names of any facilities visited, names of workers or natural supports present at the time of the incident are included in SIMS. Make sure you select an **incident category** on the CIR.
- Enter initial follow-up notes within 6 business days **for all CIRs** that affect the beneficiary’s you support, regardless of who entered the CIR. Continue to enter notes until the CIR is closed.
- DSPAs should review SIMS daily for new CIRs and/or to follow-up on existing CIRs.

- Who convenes the team meeting? Typically they are convened by the support coordinator, but it can be convened by any member of the support team. The provider, beneficiary, authorized representative or support coordinator can convene the team meeting.

Q&A –

- What do I do if I am unable to pull up the incident in SIMS. – Send email to SIMSWaiver@la.gov
- What do we do if beneficiaries are continually reporting incidents to their DSPA or DSW and the DSPA is not entering the incidents? Let OCDD SIMS staff know. Send an email to SIMSWaiver@la.gov.
- What if there is an incident that is both Adult Protective Services (APS) and non-APS related? Who enters the incident? The APS team will enter the APS portion of the incident. The provider will enter a separate CIR into SIMS for the “non-APS” portion of the incident. Example: If the incident is physical abuse and the individual goes to the ER, then APS will enter the physical abuse critical incident, and the provider will enter the ER visit critical incident. If any other incident category occurs in addition to the abuse/neglect/exploitation, then the provider is responsible for entering that portion of the incident in SIMS.
- Who enters the incident if the Support Coordinator discovers the incident during the monthly contact? It depends. In short, whichever agency first discovers or knows about the incident is responsible for entering the incident into SIMS.
 - If the DSW was on shift when the incident occurred, then the DSPA is responsible for entering the incident even if the DSW did not report the incident.
 - If the DSW or DSPA finds out about the incident before the SCA, the DSPA is responsible for entering the incident even if the DSW was NOT on shift at the time of the incident.
 - If the SCA finds out about the incident during a contact, and the DSPA is not aware of the incident, then the SCA is responsible for entering the incident.

Provider Monitoring – Janae Burr

Ms. Janae Burr reminded providers of the requirement to use the OCDD Waiver Service Log/Progress Note form. Training was provided in January 2025 on the new forms and is also posted on the LDH website. If a provider is using electronic documentation, it must contain all of the elements of the OCDD Standard Service Log/Progress Note form. All notes should contain a narrative that describes the service provided. Examples were provided in the training. All providers are being monitored for compliance.

The links for the training and forms are:

- Power Point for Progress Note Training: <https://ldh.la.gov/assets/docs/OCDD/Providers/ProviderDocumentationRequirementsTraining013125.pdf>
- Video for Progress Note Training: <https://www.youtube.com/watch?v=xHl1IPKnplI>
(Click BROWSE YOUTUBE)
- Progress Note Forms: <https://ldh.la.gov/resources?cat=44&d=0&y=0&s=0&q=progress%20note>

OCDD is currently monitoring for compliance. A total of 260 reviews have been completed. Of the reviews, 61% did not require a corrective action plan (CAP). A total of 39% did require a CAP. The monitoring started in July 2025 and the results so far are through November 30, 2025.

The graph in the power point shows the percentage for each element that required a CAP (red), required additional training (yellow), or met all requirements (green). The elements that most frequently required a CAP were 1.1, 2.2, 3.1, and 3.5. Those elements represented the following:

- 1.1 Notes present for all shifts
- 2.2 Progress Notes time matches Electronic Visit Verification (EVV) in LaSRS
- 3.1 Activities of Daily Living (ADL) did not identify the level of support delivered for each ADL provided
- 3.5 Progress Notes - descriptions were not adequate or vague
- 3.6 Challenges/Barriers descriptions or actions were not adequate

If the OCDD monitor requests a corrective action plan, providers are expected to respond promptly to the monitors. The elements of a good corrective action plan will address the following:

- Does proposed action address the problem that was identified with the progress notes that did not meet requirements?
- Does proposed action include steps to address supervisory actions or oversight that should have occurred to capture/identify problems?
- Does proposed action include steps to adjust any quality monitoring and review of progress notes to avoid the problem in the future?
- Does plan timeframe appear reasonable to address the action; sufficient time and quick enough to address as soon as practical?
- Does the proposed action from the provider include review and adjustment if needed for new staff training to reduce likelihood of similar problems in the future?

The intent of the corrective action plan is to foster improvement in the quality of documentation prepared for these services. Assigning action to a specific person to ensure all activities in the CAP are completed as needed is recommended. All agencies will be monitored. The plan is for all providers to be monitored on an annual basis.

Involuntary Discharge from a Provider Agency – Kim Kennedy

If a provider agency is considering an involuntary discharge for a beneficiary with their agency, there are several things that should happen first. Providers should work with the beneficiary to resolve issues and give them the opportunity to correct the issue. An individual should know if involuntary discharge is being considered. Providers should request an interdisciplinary team (IDT) meeting prior to involuntary discharge and include the Local Governing Entity (LGE) if the issues are significant. The discharge notice must follow all of the requirements listed in the HCBS Licensing Rule.

Support Coordinators should contact the beneficiary immediately when they are notified of an involuntary discharge and tell the individual about their appeal rights to continue services during the

discharge process. Support coordinators should also offer Freedom of Choice to the beneficiary and immediately begin an expedited search for a new provider. Additionally, the support coordinator should meet regularly with the individual to help secure a new provider and keep the LGE informed of actions taken. The LGE should also stay in communication with the support coordinator regarding locating a new provider.

Q&A

For a behavioral health referral, who needs to contact the behavioral health provider? Go to LaSRS and find the behavioral health plan in which they are enrolled. You can reach out to the LGE to access the ACT team or for assistance with the OCDD Resource Center. Things typically do not get urgent quickly. Ensuring that individuals have meaningful day activities through planning can also help mitigate challenges and behavioral issues. When you plan for jobs and community activities, you may not experience as many behavioral issues.

What happens if the beneficiary decides to switch agencies and the provider agency is not aware of the change? Support coordinators are responsible for coordinating the transfer from one agency to another and notifying the provider agency that the individual is switching providers. A provider should not find out after the fact that someone has left their agency. Providers are responsible for continuing to provide services after they have been notified of the request to change providers. A provider cannot discontinue services until their prior authorization for services has ended. Support coordinators should ensure there is no gap in services during the transition.

Span Date Billing – Kim Kennedy

Span date billing for OCDD in-home services (S5125) is no longer allowed for dates of service 12/1/25 and later. A span date is a single claim that covers multiple days (i.e., 12/1/25 – 12/15/25). Providers will receive a denial code of “351- span date not allowed, must bill per day”. This does not change the frequency of when you submit your billing. It only affects the dates that can be on a single claim.

Participant Liability Income (PLI) – Waiver Spenddown – Kim Kennedy

Our waiver applications that go to CMS require us to identify how we will treat a person’s income for the waiver. The OCDD waivers have the “Waiver Spenddown” option for how we will treat a beneficiary’s income, also known as PLI. This allows them to spenddown some of their income and keep the waiver. Support Coordination agencies receive the decision notice that identifies if a person is in a spenddown waiver and the amount of their PLI. The support coordinator needs to notify providers that an individual they are supporting has a PLI. Providers are responsible for having an agreement with the beneficiary to pay their portion of the PLI. Provider claims will be reduced by the PLI amount and will have an edit code of 919 on the remittance advice.

Service Billing Match to LaSRS – Kim Kennedy

OCDD will start matching service information in LaSRS to billing submitted. This is happening now, but providers are only receiving educational edits (not denials) with the code 370, 450, 651, or 700. Once all testing has finished, we will start denying services with these codes. Providers will be notified when this is implemented.

Providers must ensure that they are billing based on services entered **and** released in LaSRS. Each claim will be matched to LaSRS for the beneficiary, date of service, and procedure code including modifiers. If there is not a match in LaSRS for these elements, the claim will be denied.

Community Life Engagement Development (CLED) – Rosemary Morales

Ms. Morales presented on the CLED service that is available to Day Habilitation providers. A tip sheet is also being provided as an attachment to these notes. This service is designed to help a provider locate and develop opportunities in the community that reflect the interests of the individual or exploring new activities that lead to new interests.

An individual must have Day Habilitation on their plan of care to receive the CLED. Please refer to the power point labeled “Community Life Engagement Development”. The service is available in the NOW, ROW and Supports Waiver. The service may be provided in 1:1, 1:2 or 1:3. Only put the 1:1 code on the plan of care or revision. The service should be billed when initially establishing a connection with a community organization. Transportation is included in the rate.

The requirements for this service are:

- Provided by the Day Habilitation provider,
- EVV is required when contact is made with the community organization
- CLED Contact Form must be completed for each individual and a copy sent to the LGE and support coordinator.
- Provider should be prepared to discuss the contacts and community connections made at the person’s quarterly meeting and how this has facilitated an increase in the individual’s community live engagement activities.

Rosemary also informed providers that the new OCDD Fee Schedules are posted on LaMedicaid.com.

Final Comments

Teresa Frank reminded providers to make sure individuals had working fire alarms in their homes, one on each floor. If you need assistance with getting a fire alarm, check with your local fire department.

Ms. Frank also noted that the contract with one of the Louisiana MCO’s, United Health Care is not being renewed. Individuals can call 1-855-229-6848 for more information.

Next OCDD Quarterly Provider Meeting is scheduled for Wednesday, March 18, 2026 at 10:00 a.m.