



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 (CCW) is a Medicaid Home and Community-Based Services Waiver providing an array of alternative services to individuals that assist them to live in their own home or community instead of in 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 Louisiana Department of Health (LDH) 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 provide CCW providers and support coordination agencies with the 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 an agency or provider to remain in compliance with federal and state laws and department rules.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website (below) for general information concerning topics relative to Medicaid provider enrollment and administration.

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

The LDH Bureau of Health Services Financing (BHSF), Office of Aging and Adult Services (OAAS), and Health Standards Section (HSS) are responsible for assuring oversight of the waiver services, licensure compliance, program monitoring, and overall compliance with the rules and regulations.

Waiver services to be provided are specified in the Plan of Care (POC) which is written by the support coordinator, based on input from the planning team. 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 POC 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 POC (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

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based on the approved POC.

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 and Medicaid Services (CMS).

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SECTION 7.1: COVERED SERVICES

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 and Re-assessment;
- Plan of care development and revision;
- Follow-up/Monitoring;
- Critical incident management; and
- Transition/discharge and closure.

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

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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 "*Community Choices Waiver Self-Direction Employer Handbook*".)

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.)

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 (not to exceed 180 calendar days) from the POC approval date so long as the recipient is residing in the nursing facility. 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.

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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.

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, including outstanding balances for past due charges and/or fees.
- Activities to assess need, arrange for and procure needed resources (e.g. fees associated with obtaining photo IDs or vital records, housing application fees, etc.)
- 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;

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- 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.

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 individual, 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.

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 EAA as indicated by the interRAI Home Care Assessment or other supporting documentation.

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 access evaluation (HAE) 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

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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 HAE 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.

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;

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- 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;
 - 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.**

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;

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- Vehicle adaptations;
- 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.

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

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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 (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 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. 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.

When recipients plan to travel outside of Louisiana, there must be a written request (that includes

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a detailed explanation) submitted 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
 - Assisting the recipient with adaptive feeding devices

NOTE: Assistance does NOT 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;

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- 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
- 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.

NOTE: Assistance does NOT include removing or changing bags or tubing, inserting, removing and sterilizing irrigation of catheters unless the DSW has received the required training pursuant to R.S. 37:1031-1034.

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Assistance or support with ADL tasks does not include teaching family/friends/others how to care for the recipient.

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;
- 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

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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;
- Accompany the recipient to medical appointments and provide assistance throughout the appointment.

Protective Supervision

Protective supervision may be provided to assure the health and welfare of a recipient who has cognitive or memory impairment or who has physical weakness as defined by the OAAS comprehensive assessment. The worker must be with the recipient, be awake, alert and available to respond to the recipient's immediate needs.

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

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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). Recipients receiving shared PAS must each be:

- Approved to receive CCW;
- Share the same residence; and
- Have a common 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.

Service Exclusions

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

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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
- 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

There shall be no duplication of services.

PAS may not be provided while the recipient is attending or admitted to a program or setting that provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided. IADLs may not be performed in the recipient’s home when the recipient is absent from the home.

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.

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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.

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.

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 licensed non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the recipient.

An ADHC center shall, at a minimum, furnish the following services in accordance with licensing regulations:

- Training or assistance with Activities of Daily Living (toileting, grooming, eating, ambulation, etc.);
- Health and nutrition counseling;
- Individualized daily exercise program;
- Individualized, goal-directed recreation program;
- Health education;
- Medical care management;

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- 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.

- Nursing services that are provided by licensed nursing professionals and that include the following individualized health services:
 - 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 recipients' medication administration plans (self-administration and staff administered) of medications while the recipient is at the ADHC center; and
 - Serving as a liaison between the recipient and medical resources including the treating physician.

NOTE: All nursing services shall be provided in accordance with professional practice standards and all other requirements identified in the ADHC licensing rules.

- Transportation between the recipient's place of residence and the ADHC center at the beginning and end of the program day
 - The cost of transportation is included in the rate paid to ADHC centers. The recipient and his/her family may choose to transport the recipient to the ADHC center. Transportation provided by the recipient's family is not a reimbursable service;

NOTE: An ADHC center may serve a person residing outside of the ADHCs licensed region, however, transportation by the ADHC center is not required.

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

Service Exclusions

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

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ADHC services may not be billed at the same time as PAS and/or caregiver temporary support services.

Service Limitations

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

ADHC services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours per week (exclusive of transportation time to and from the ADHC center, as specified in the recipient's POC and ADHC ISP).

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/Adult Residential Care facilities;
- Respite centers; or
- ADHC centers.

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

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more than ten hours per day.

Service Exclusions

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.

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. When recipients plan to travel outside of Louisiana, there must be a written request (that includes a detailed explanation) submitted to OAAS or its designee at least 24 hours prior to the anticipated travel (when applicable).

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;

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- Supervision or assistance while escorting/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; 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.

Providers capture daily notes electronically to monitor the recipient's health and the 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 (PAS);
- Adult Day Health Care (ADHC) 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 ADL or

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IADL assistance.

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.

Assistive Devices and Medical Supplies

Assistive devices and medical supplies are specialized medical equipment and supplies that include:

- Devices, controls, appliances or nutritional supplements specified in the POC that enable recipients to increase their abilities to perform ADLs;
- Devices, controls, appliances or nutritional supplements specified in the POC to perceive, control, or communicate with the environment in which they live or provide emergency response;
- Items, supplies and services necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items;
- Supplies and services to assure recipients health and welfare;
- Other durable and non-durable medical equipment and necessary medical supplies that are not available under the state plan;
- Personal Emergency Response System (PERS); and
- Other in-home monitoring and medication management devices and technology;
- Routine maintenance or repair of specialized equipment; and
- Batteries, extended warranties, and service contracts that are cost effective and assure health and welfare.

This includes medical equipment not available under the State Plan that is necessary to address recipient functional limitations, and necessary medical supplies not available under the State Plan that are included in the POC or other supporting documentation (e.g. assessment, SC documentation, etc.).

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

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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 installed in his/her home. It must meet Federal Communications Commission standards or Underwriter's Laboratory (UL) standards or equivalent standards.

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.

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.

Monthly telecare services consist of:

- 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;

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- 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.

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

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;
- 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

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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.

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 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.

Service Exclusions

No experimental items are allowed.

Service Limitations

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 must be performed by individuals who have no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

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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 services and traditional PERS services.

Home Delivered Meals

The purpose of home delivered meals is to assist recipients in meeting their nutritional needs to support and maintain self-sufficiency and enhance 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.

The meal is delivered to the recipient's home.

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. The maximum cost is \$7 per meal.

Nursing

Nursing services are services that are medically necessary and may be provided efficiently and

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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.

Service Exclusions

Nursing care shall not be provided when the recipient is an inpatient at a hospital or in a nursing facility. Assessments are allowed. (See Appendix F for a list of Concurrent Services.)

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.

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.

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

Skilled Maintenance Therapy (Physical, Occupational, Respiratory and

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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, work, or in a rehabilitative center/clinic.

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 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.

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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;
- 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 exercises 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;

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- 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.

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.

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.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

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

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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 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

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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.

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.

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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.

Hospice and Waiver 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 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 be licensed by LDH-HSS and 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 in accordance with hospice licensing regulations.

Once the hospice program requirements are met, then CCW Personal Assistance Services (PAS) can be utilized for those personal care tasks with 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) 2**

SELF-DIRECTION OPTION

Self-Direction is a voluntary service delivery option in the Community Choices Waiver (CCW) that allows recipients to become the employers (rather than a licensed, enrolled provider as the employer) of the individuals they choose to hire to provide Personal Assistance Services (PAS) to them. As the employers, recipients, or their responsible representative, are responsible for recruiting, training, supervising, and managing the individuals they choose to hire.

A requirement under this option is the use of an approved contracted Fiscal Employer Agent (FEA) who will perform the recipient's employer-related payroll functions.

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 *Community Choices Waiver Self Direction 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 provided by the support coordinator;
- Understand the rights, risks, and responsibilities of self-direction;
- Manage and use an individual budget; and

NOTE: If the recipient is unable to make decisions independently, they must 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.

- Comply with all state and federal laws and regulations including but not limited to minimum wage and overtime requirements.

Termination of the Self-Direction Option

Termination from this option may be either voluntary or involuntary and the support coordinator will assist with the transition. A revision of the plan of care by the support coordinator is required

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SECTION 7.2: SELF-DIRECTION OPTION

in order to eliminate the FEA and add the recipient's chosen Medicaid-enrolled Direct Service Provider(s) (DSPs).

Recipients who return to traditional DSP must remain with this DSP for at least 90 calendar days (three months) before opting to return to the self-direction option if they are eligible to do so.

Recipients may choose at any time to voluntarily return to a traditional DSP.

A recipient may be removed from Self-Direction and required to return to traditional DSP if there are any violations of the CCW or Self-Direction program rules.

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SECTION 7.3: RECIPIENT REQUIREMENTS

RECIPIENT REQUIREMENTS

The Community Choices Waiver (CCW) program is only available to individuals/recipients who meet the following criteria:

- Medicaid financial eligibility;
- 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;
- Nursing facility level of care requirements;
- Name on the Request for Services Registry for CCW; and
- Plan of Care (POC) 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 CCW 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 admission or discharge from the CCW.

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

Request for Services Registry

The Louisiana Department of Health (LDH) is responsible for the Request for Services Registry (RFSR), hereafter referred to as “the registry,” for the CCW. 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 CCW services shall be accepted from the following:

- The applicant;
- An individual who is legally responsible for the applicant; or

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SECTION 7.3: RECIPIENT REQUIREMENTS

- A responsible representative designated by the applicant to act on his/her behalf.

Individuals will be screened and/or assessed to determine whether they meet nursing facility level of care and are members of the target population. Only individuals who meet these criteria will be added to the registry. The individual’s name is placed on the registry in request date order.

NOTE: If at any time individuals do NOT meet nursing facility level of care, their names will be removed from the CCW registry.

Priority Groups for Waiver Offers

CCW offers shall be presented 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) and who, without Community Choices Waiver services, would require institutional placement to prevent further abuse and neglect as determined by OAAS review;
- Individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS);

Individuals who are residing in a state of Louisiana permanent supportive housing (PSH) unit or who are linked for the state of Louisiana PSH program;
- Individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for their nursing facility stay;
- Individuals who are not presently receiving home and community-based services under another approved Medicaid program, including, but not limited to:
 - Program of All-Inclusive Care for the Elderly (PACE);
 - Long Term – Personal Care Services (LT-PCS); and/or
 - Any 1915(c) waivers; and
- All other eligible individuals on the registry, by date of first request for services.

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 priority group, is notified and the process continues until an individual is determined eligible.

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

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

A limited number of waiver opportunities may be granted to qualified individuals who require expedited CCW services. These individuals shall be offered a CCW opportunity on a first-come, first-served basis. To be considered for an expedited CCW 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 CCW 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 CCW:

- The individual does not meet the target population criteria;
- The individual does not meet the criteria for Medicaid eligibility;
- The individual does not meet the criteria for a nursing facility level of care;

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- The individual/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 CCW 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. This exception is granted by OAAS and will not typically exceed 90 consecutive days.

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

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SECTION 7.4: RECIPIENT RIGHTS/RESPONSIBILITIES PAGE(S) 6

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 (CCW) 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 CCW services. The recipient has the right to change his/her responsible representative at any time. 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 (unless an exception is granted by OAAS) which includes, but is not limited to:

- Program of All-Inclusive Care for the Elderly (PACE);
- Long-Term Personal Care Services (LT-PCS);
- Community Choices Waiver (CCW); and
- 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 are informed of their alternatives under the waiver at the time they are going through the Medicaid application and determination process. These individuals have the responsibility to participate in this process which includes providing medical and other pertinent information or assisting in obtaining this information to be used in the person-centered planning and service approval process. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

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Freedom of Choice of Agencies/Providers

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

Type of Service	Without Good Cause	With Good Cause
Transition Service	Not applicable	Not applicable
Personal Assistance Service	Every three months based on a calendar quarter	Any time
Transition Intensive Support Coordination Support Coordination	Recipients must have been with the agency at least six months	Any time
Adult Day Health Care	Once every six months with the change effective beginning the 1 st day of the following calendar quarter	Any time
Environmental Accessibility Adaptation Skilled Maintenance Therapy Nursing Assistive Devices and Medical Supplies Caregiver Temporary Support Service Home Delivered Meals Monitored In-Home Caregiving Services	Every six months	Any time

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Good cause is defined as:

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

Support coordinators will provide recipients with their choice of providers and help arrange and coordinate all the services on the Plan of Care (POC).

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

Adequacy of Care

All recipients in home and community-based services waiver programs have the right to choose and receive the services necessary to support them to live in a community setting. Recipients have the right to choose how, where, and with whom they live. Services are arranged and coordinated through support coordination 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 employees, providers or support coordinators. Units of service are not "saved up". The services are certified as medically necessary for the recipient to be able to stay in the community and are revised on the POC as each recipient's needs change. The support coordinator must be informed any time there is a change in the recipient's health, medication, physical conditions, and/or living situation.

Participation in Care

Each recipient shall participate in the 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

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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 is expected to participate in the planning process to the best of the recipient's ability so that services can be delivered according to the approved person-centered POC. 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 to the support coordinator as soon as the need is identified. The support coordinator will prepare and submit the POC revision in accordance with the required timelines. Providers may not initiate a request for change/adjustment of service(s), or modifications to the POC, 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 or participate in activities that they do not want, even if they are eligible for these services. The intent of CCW 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.

Quality of Care

Each home and community-based services waiver recipient has the right to be treated with dignity and respect and receive services from provider employees who have been trained and are qualified to provide them. In addition, providers are required to maintain privacy and confidentiality in all interactions related to the recipient's services.

Recipients have the right to be free from abuse (mental, physical, emotional, coercion, restraints, seclusion, and any other forms of restrictive interventions).

In cases where services are not delivered according to the approved POC, or there are allegations of abuse, neglect, exploitation, or extortion, the recipient shall follow the reporting procedures and inform the support coordinator, provider, and appropriate authorities.

Recipients and providers shall cooperate in the investigation and resolution of reported incidents/complaints.

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Recipients must maintain a safe and lawful home environment and may not request providers to perform tasks that are illegal or inappropriate, and they may not violate the rights of other recipients.

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 CCW recipients. In order to maintain eligibility, recipients and providers have the responsibility to inform BHSF of changes in the recipient's income, resources, address, and living situation.

OAAS or its designee is responsible for approving level of care and medical certification. Recipients and their providers have the responsibility to inform the OAAS of any changes which affect programmatic waiver eligibility requirements, including changes in level of care.

Grievances/Complaints

The recipient has a responsibility to bring problems to the attention of providers or the Medicaid program and to file a grievance/complaint without fear of retribution, retaliation, or discharge.

All support coordination and direct service providers must have grievance procedures through which recipients may voice complaints regarding the supports or services they receive. Recipients must be provided a copy of the grievance procedures upon admission to a direct service provider and complaint/grievance forms shall be given to recipients thereafter upon request. It is the recipient's right to contact any advocacy resource as needed, especially during grievance procedures.

If recipients need assistance, clarification, or to report a complaint, toll-free numbers are available (See Appendix A for contact information).

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SECTION 7.4: RECIPIENT RIGHTS/RESPONSIBILITIES PAGE(S) 6

Fair Hearings

Recipients must be advised of their rights to appeal any agency action or decision resulting in suspension, reduction, discontinuance, or termination of services. Recipients have the right to a fair hearing through the Division of Administrative Law (DAL). In the event of a fair hearing, a representative of the DSP and support coordination agency must participate by telephone, or in person, if requested.

An appeal by the recipient may be filed with DAL via fax, mail, online request, or by telephone. (See Appendix A for contact information.) Instructions for submitting appeal requests are also included in all adverse action notices.

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 Services (HCBS) Waiver* form)

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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 CCW 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 CCW Services Decision Form and a Support Coordination Agency Freedom of Choice (FOC) and Release of Information form.

The applicant must complete and return the packet if interested in accepting the 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 eligibility office.

Once it has been determined 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 list. 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;
- Completing assessment and POCs;
- Obtaining an agreement from the selected provider(s) to provide services, (for ADHC, SC will also obtain completed assessment and/or plans written by the provider); 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: Authorization to provide service is always contingent upon having an approved POC or POC revision.

Prior Authorization

All services under 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 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.

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The 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;
- 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;
- Verifying that services were delivered according to the recipient's approved POC prior to billing for the service;
- Proper use of the Electronic Visit Verification (EVV) system (if applicable);
- 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: Providers have one-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in Chapter General Information and Administration of the Medicaid Services Manual at:

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

Support Coordination

Authorizations for support coordination service are issued by the data contractor for the POC year. A service unit is one month and each authorization covers a maximum of seven months, or seven service units. Typically, two PAs will be issued for a one-year POC. 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 (TISC) 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

Authorization for transition services has a lifetime cap of \$1500. The authorization period is the effective date indicated on the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the "Transition Services 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 revision) that indicates a need for an environmental accessibility adaptation (EAA), an authorization is issued for a basic assessment to the assessor. After the data contractor receives documentation that the assessor has completed the assessment, the PA for approval services is released.

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

- An authorization for the final inspection and approval to the assessor; and
- An authorization for the installation/completion of the EAA to the provider/contractor.

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Upon receipt of documentation (either from the assessor or OAAS) that these tasks have been completed, the data contractor will release the PAs for payment.

Personal Assistance Services

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

A unit of service is:

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

Approved units of service are calculated on a weekly basis to the provider and must be used for the specified week.

PAs are released on a daily basis after services are provided and documented in the Electronic Visit Verification (EVV) system. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes a week is defined as beginning at 12:00 am Sunday and ending at 11:59 pm the following Saturday. Payment for services is capped for each week.

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 PAS should refer to the *Community Choices Waiver Self-Direction Employer Handbook*. (See Appendix B for information on accessing this handbook.)

Adult Day Health Care

ADHC service units are 15 minutes. ADHC services are assigned a PA number for the year. Approved units of service are issued on a quarterly basis. PAs are released after services are provided and documented in the EVV system. Units of service approved for one week cannot exceed established limits. For PA purposes, a week is defined as beginning at 12:00 am Sunday and ending at 11:59 pm the following Saturday. Payment for services is capped at 50 hours per week and no more than 10 hours per day.

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

Caregiver Temporary Support

Authorization for caregiver temporary support service is issued for no more than 30 calendar days or 29 overnight stays per POC year. Each PA is capped at 14 calendar days or 13 overnight stays and no contiguous PAs are issued.

A unit of service is:

Type of Delivery Method	Unit of Service
In the home	15 minutes
Assisted Living Facility; Nursing Facility; Respite Care Center (ALL overnight)	Daily
ADHC center (not overnight)	15 minutes (maximum of 40 units/day)

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

Assisted living centers, nursing facilities and respite care centers use the Louisiana Service Reporting System (LaSRS) to retrieve PAs, but do not utilize LaSRS to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Monitored In-Home Caregiving Services

Authorization for monitored in-home caregiving (MIHC) services is issued upon receipt of the POC (initial, provisional, or revision).

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A service unit is:

Type of Delivery Method	Unit of Service
MIHC (Level 1 and Level 2 services)	Per day
Intake and assessment	Per Service

This provider type uses LaSRS to retrieve PAs, but do not utilize LaSRS to document the provision of services.

The intake and assessment PA will be released once the MIHC Services Form is submitted to the data contractor by the support coordinator. “Per Day” units may be billed using the proper PA, after services are delivered.

Assistive Devices and Medical Supplies

Authorization for assistive devices and medical supplies will be issued upon receipt of the POC (initial, provisional, or revision).

A service unit is:

Type of Delivery Method	Unit of Service
PERS Installation Telecare Installation	One Time Fee
PERS Maintenance Telecare Maintenance	Per Month
Medication Dispensing and Monitoring	Per Month
Equipment Rental and Repairs	Pay as Approved
Equipment Purchase Medical Supply Purchase Procurement	Per Service/Pay as Approved

PERS installation and monthly units of service use LaSRS to retrieve PAs, but do not utilize LaSRS to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

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For all other “per month”, “per service” or “pay as approved” units, the prior authorization will be released for payment once the data contractor receives documentation from the support coordinator confirming the purchase/rental/repair/procurement. (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 limit of two meals per day. A service unit is one meal.

This provider type uses LaSRS to retrieve PAs, but do not utilize LaSRS to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Nursing Services

A nursing service assessment and/or ongoing nursing services are authorized upon receipt of the POC (provisional, initial or revision).

A service unit is:

Type of Delivery Method	Unit of Service
Assessment	Per Service
Nursing Care	Per Visit

Authorization is issued for no more than six months of service and in the amount indicated in the POC.

This provider type uses LaSRS to retrieve PAs, but do not utilize LaSRS to document the provision of services. The PA will be released for payment once the data contractor receives the Nursing/Therapy Payment Authorization Form from the support coordinator confirming the service/visit.

Skilled 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 revision).

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A service unit is:

Type of Delivery Method	Unit of Service
Evaluation Re-evaluation	Per Service
Therapy Home Care Training (Out-Patient)	Per Visit

Authorization is issued for no more than six months of service and in the amount indicated in the POC. The POC revision is based on the recommendations from the professional evaluation and as reflected on the CCW Nursing/Therapy Evaluation Form. (See Appendix B for link to this form.)

This provider type uses LaSRS to retrieve PAs, but do not utilize LaSRS to document the provision of services. The PA will be released for payment once the data contractor receives the Nursing/Therapy Payment Authorization Form from the support coordinator confirming the service/visit.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

Authorization for these Permanent Supportive Housing (PSH) services is made upon receipt of the POC (initial, provisional, or revision).

A unit of service is:

Type of Delivery Method	Unit of Service
Housing Stabilization	Per 15 minutes (maximum of 72 units per POC year)
Housing Transition or Crisis Intervention	Per 15 minutes (maximum of 96 units per POC year)

These provider types use LaSRS to retrieve PAs, but do not utilize LaSRS to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Post Authorization

Some services require post authorization before the provider is able to bill for services rendered.

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Post authorization may occur either through EVV or through documentation submitted by the support coordinator as follows:

EVV	Additional Documentation
Personal Assistance Service (PAS)	Skilled Maintenance Therapies
Adult Day Health Care (ADHC)	Assistive Devices and Medical Supplies (excluding PERS)
Caregiver Temporary Support In-home	Nursing
Caregiver Temporary Support ADHC and center based (not overnight)	MIHC Intake and Assessment
	Transition Services
	Environmental Accessibility Adaptation

The data contractor checks the information reported against the prior authorized units of service. Once post authorization is granted, the 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.

Changing Providers

Recipients or their responsible representative must request any change in amount(s) of service/units to the support coordinator.

All requests for changes in providers require a new Freedom of Choice by the recipient or his/her responsible representative (Refer to 7.4-Recipient Rights and Responsibilities, Freedom of Choice of Providers, for details on “good cause” criteria and timelines.)

The support coordinator will provide the recipient with the current FOC provider list for 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 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

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progress summaries (if applicable);

- Current Individualized Service Plan, current assessments upon which the Individualized Service Plan is based (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;
- Number of services used in the calendar year; and
- All other waiver documents necessary for the new provider to begin providing services.

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

Prior Authorization for New Providers

The support coordinator will complete a POC revision 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 provider's PA number will expire on the end date as indicated on the POC revision.

Changing Support Coordination Agency

Recipient(s) may request a change in Support Coordination Agency through the support coordinator or by contacting OAAS regional office. (Refer to 7.4-Recipient Rights and Responsibilities, Freedom of Choice of Providers, for details on "good cause" criteria and timelines.)

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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 Transfer of Records form. 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 Support Coordination Documentation (SCD).

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 must 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 must 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.

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.

OAAS or its designee 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.

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);
- 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 should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website. Section 1.1 - Provider Requirements contains detailed information concerning topics relative to Medicaid provider enrollment. (<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>)

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 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.

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Providers must also check the certified nursing assistant (CNA) and direct service worker (DSW) Registries for placement of findings of abuse, neglect, or misappropriation and shall be in accordance with licensing regulations.

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.

Providers must participate in the initial training for prior authorization (PA) and data collection and any training provided on changes in the system. Initial training is provided at no cost to the provider. Any repeat training must be paid for by the requesting provider.

PAS and adult day healthcare (ADHC) providers must have available computer equipment, software, and internet connectivity necessary to participate in PA, data collection, and Electronic Visit Verification (EVV).

Waiver services are to be provided strictly in accordance with the provisions of the approved POC. All providers and support coordination agencies are obligated to immediately 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.

PAS providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety 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 and timelines. (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

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Verification (EVV) as applicable.

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
<p>Provided by a support coordination agency that:</p> <ul style="list-style-type: none"> • Is certified by the Louisiana Department of Health (LDH)/OAAS to provide support coordination services; • Has signed the OAAS Performance Agreement; • 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 a completed OAAS agency contact information form to OAAS; • Has enrolled as a Medicaid provider of support coordination services in all regions in which it intends to provide service; and • Is listed on the Support Coordination Agency Freedom of Choice (FOC) form.

CHAPTER 7: COMMUNITY CHOICES WAIVER**SECTION 7.6: PROVIDER REQUIREMENTS****PAGE(S) 19****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** that:

- 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** that:

- 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** that:

- Is licensed by the LDH Health Standards Section (HSS) as an ADHC provider in accordance with Louisiana Revised Statute 40:2120.47;
- Has enrolled in Medicaid as an ADHC provider; and
- Is listed on the ADHC FOC form.

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** that:

- 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** that:

- 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** that:

- 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** that:

- 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** that:

- 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** that:

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

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Assistive Devices and Medical SuppliesProvided by a **Durable Medical Equipment (DME) provider** that:

- 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** that:

- 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 that:

- 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** that:

- 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** that:

- 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** that:

- 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** that:

- 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** that:

- 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** that:

- 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 provider

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

- The provider shall give 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, behavioral issues, social issues and nutritional status of the recipient; and

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- 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 OAAS Home and Community-Based Services Waivers Support Coordination Standards for Participation rule and comply with all LDH and OAAS policies and procedures;
- 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;
- 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;
- Assure staff attends all training mandated by OAAS; and
- 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 *CCW 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

Providers are required to ensure that all modifications, adaptations, additions or repairs are made in accordance with all of the local and state housing and building codes, and must meet the Americans with Disabilities Act requirements.

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

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- **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.

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

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- 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 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

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.

When permissible (see PAS Service Exclusions in Section 7.1- Covered Services), family members who provide personal assistance services must meet the same standards for employment as caregivers who are unrelated to the recipient.

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. 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.

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.

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

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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.

PAS providers must cooperate to ensure timely completion of the “OAAS Emergency Plan” for each waiver recipient they serve (See Appendix B for information on accessing this form.)

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

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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 must:

- Comply with all applicable LDH rules and regulations including the use of an approved Electronic Visit Verification (EVV) system.
- Provide transportation to any recipient within their licensed region in accordance with ADHC licensing standards.

NOTE: An ADHC center may serve a person residing outside of the ADHCs licensed region, however, transportation by the ADHC center is not required.

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 Providers

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.

Monitored In-Home Caregiving Service Providers

Monitored in-home caregiving providers must comply with LDH rules and regulations and be

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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.

Assistive Devices and Medical Supply Service Providers

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.

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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 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.

Home Delivered Meal Providers

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.

Nursing Providers

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. 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.)

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Skilled Maintenance Therapy Providers

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

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.

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

Housing transition or crisis intervention services and housing stabilization services providers must be 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.

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 in writing to HSS, OAAS and the fiscal intermediary’s Provider Enrollment Section within the time specified in the HSS licensing rule:

- Provider’s entity name (“doing business as” name);
- Key administrative personnel;
- Ownership;
- Physical location;

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

When a provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 30-day written advance notice to all recipients served and their responsible representatives, support coordination agencies, and LDH (OAAS and HSS – if licensed) prior to discontinuing service.

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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 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 information

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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 provider, 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 provider's site.

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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.

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

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.
Annual Contacts	Complete in the last month of the POC year at the time of the annual monitoring contact, according to OAAS documentation and data entry requirements. NOTE: The annual monitoring may be performed at the same time as the monthly monitoring or at another time during the last month of the POC year.
Case Closure/Transfer	Complete within 14 calendar 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.

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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).
Case Closure/Transfer	Complete within 14 calendar days of discharge.

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 calendar days.
Case Closure/Transfer	Complete within 14 calendar days of discharge.

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

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

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.

Caregiver Temporary Support Providers	
Service Log	Refer to Appendix B for form/instructions.

Monitored In-Home Caregiving Service Providers	
Daily Electronic Notes	Sent via secure web-based exchange documenting delivery of services and overall condition; sent daily

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.

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Permanent Supportive Housing Providers	
*Progress Notes	Complete at the time of activity.
Case Closure/Transfer	Complete within 14 calendar 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 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.

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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.)

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 (PAS and ADHC), 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. PAS 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.**

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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
- 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.

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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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REIMBURSEMENT

Reimbursement for Community Choices Waiver services vary based on the type of service being provided. 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).

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.

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/provider 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.

Refer to Appendix D of this manual chapter for information about claims filing.

Support Coordination

Support coordination is reimbursed at an established monthly rate (see to Appendix C – Billing Codes). 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, and the "Request for Payment/Override Form" has been completed and submitted to the office of Aging and Adult Services (OAAS) Regional Office for approval.

Transition Intensive Support Coordination

Transition Intensive Support Coordination (TISC) is reimbursed at an established monthly rate (see to Appendix C – Billing Codes), for a maximum of six months (not to exceed 180 calendar days) from the POC approval date so long as the participant is residing in the nursing facility. 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 period in which prior authorization is requested.

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Transition Services

Transition services are reimbursed only for the exact amount of expenditures indicated on final approval and supporting documentation. 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 revision) that includes the transition services, the receipts for the purchases and the “Transition Services Form (TSF)” are sent to the data contractor. (See Appendix B for a copy of this form).

The support coordination agency is then 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 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.

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.

NOTE: 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, the OAAS Regional Office must notify OAAS State Office to review for exception.

Environmental Accessibility Adaptation

Environmental Accessibility Adaptation (EAA) services are reimbursed in the amount authorized in the POC or POC revision. 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

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billing. The PA is released upon completion and submission of the EAA Form by the support coordinator.

Personal Assistance Services

Personal Assistance Services (PAS) providers are reimbursed at a per quarter-hour-rate for services provided under a Prospective Payment System (PPS) that recognizes and reflects the cost of direct care services provided.

Release of PA for PAS is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. EVV is mandatory for PAS. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OAAS. The system is to be used to electronically “check in” and “check out” when the PAS worker begins and when they end service delivery for a participant.

While there may be some circumstances that require manual edits by the provider’s designee, these should only be occasional. In the event that there is a billing overlap, the provider that uses the EVV system correctly (i.e. data has not been manually added or edited) will have priority for payment.

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. Each recipient must be present to receive the shared services in order for the provider to bill for the service.

Adult Day Health Care

Adult Day Health Care (ADHC) providers are reimbursed at a per quarter-hour-rate for services provided under a Prospective Payment System (PPS) that recognizes and reflects the cost of direct care services provided.

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 participants when they arrive and when they leave the ADHC center. While there may be some circumstances that require manual edits, these should only be occasional.

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

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

Caregiver Temporary Support Services

For providers of overnight Caregiver Temporary Support Services (CTSS), 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. Providers may bill for the service after the service has been delivered.

In-home, ADHC, and center based caregiver temporary support (not overnight) requires post authorization by way of EVV.

Monitored In Home Caregiving

Reimbursement for the monitored in-home caregiving (MIHC) intake and assessment is based on a set fee. The PA is released once the MIHC Services Form has been completed and submitted to the data contractor by the support coordinator.

Reimbursement for daily MIHC services is based upon a two-tiered model based on the results of the recipient’s assessment.

Tier Level	RUG Categories
Tier 1	Special Rehabilitation <ul style="list-style-type: none">• 1.21• 1.12• 1.11
	Special Care <ul style="list-style-type: none">• 3.11
	Clinically Complex <ul style="list-style-type: none">• 4.31• 4.21
	Impaired Cognition <ul style="list-style-type: none">• 5.21

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Tier Level	RUG Categories
	Behavior Problems <ul style="list-style-type: none"> • 6.21
	Reduced Physical Function <ul style="list-style-type: none"> • 7.41 • 7.31
Tier 2	Extensive Service <ul style="list-style-type: none"> • 2.13 • 2.12 • 2.11
	Special Care <ul style="list-style-type: none"> • 3.12

The MIHC provider may bill for services after service delivery.

Assistive Devices and Medical Supplies (AD/MS)

Reimbursement for the Personal Emergency Response System (PERS) is based on a set installation fee and a monthly maintenance fee. The PERS provider may bill for services after they are delivered.

Reimbursement for Telecare 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 qualified professional should the collected data warrant a visit. Should the recipient require additional visits during the month, those visits must be conducted by a nurse, authorized by the support coordinator and provided under Nursing Service. If the data indicates a potential emergency, the provider may dispatch a qualified professional without consultation for approval with the support coordinator; however, the support coordinator must be contacted by the next business day to request retroactive 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.

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

Home Delivered Meals

Reimbursement for meals must not exceed the set rate. The provider uses the PA to bill for services after the meals have been delivered.

Providers may span date bill for up to a two weeks supply of meals.

Nursing Services

Providers of nursing services are reimbursed at a set rate per visit. The support coordinator will complete and submit the Nursing/Therapy Payment Authorization Form to the data contractor after verifying that the services were delivered. The PA will then be released for payment and the provider may submit billing using the proper PA.

Skilled Maintenance Therapy Reimbursement

Providers of skilled maintenance therapy (SMT) are reimbursed at a set rate per visit. The support coordinator will complete and submit the Nursing/Therapy Payment Authorization Form to the data contractor after verifying that the services were delivered. The PA will then be released for payment and the provider may submit billing using the proper PA number.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

These services are reimbursed at a set rate and in the amount authorized in the approved POC or POC revision. The provider may bill the Medicaid fiscal intermediary using the proper PA after services have been provided.

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

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Services that <u>CANNOT</u> be Span-Dated	Services that <u>CAN</u> be Span-Dated
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 (CCW) are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal rules and regulations. Oversight is conducted through licensure compliance and program monitoring. The Louisiana Department of Health (LDH) Health Standards Section (HSS) staff conducts on-site reviews to assure state licensure compliance for the providers for 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

HSS reviews include 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 (POC) and Individualized Service Plan (ISP), if applicable;
- 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;
- Personnel Record Review;

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- Interviews;, and
- Recipient Record Reviews.

Administrative Review

The Administrative Review includes:

- A review of administrative record,;
- A review of other agency documentation,; and
- Provider 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 monitoring 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 employee;
- Members of the recipient's network of support, which may include family and friends;
- Direct care staff; and
- Other members of the recipient's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, direct service providers and other employees of the direct service provider.

This interview process is to assess the overall satisfaction of recipients regarding the provider agency's performance, and to determine the presence of the personal outcomes defined and prioritized by the recipient/legal guardian.

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 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 POC and ISP (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 CCW recipient's eligibility and procedural safeguards, support coordination and professional assessments/reassessment

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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. 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.

The review report includes:

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

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 monitoring 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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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 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 monitoring 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, recoupments and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) and/or Program Integrity Section. LDH 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 the Centers for Medicare and Medicaid Services (CMS) also conduct investigations of Medicaid fraud.

Support Coordination Monitoring

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

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

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

- Offering full cooperation with 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.

Providers may refer to Appendix B of this manual chapter for further information regarding the Support Coordination Monitoring process.

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SECTION 7.10: INCIDENTS, ACCIDENTS AND COMPLAINTS**PAGE(S) 3**

INCIDENTS, ACCIDENTS AND COMPLAINTS

Support coordinators, ADHC providers 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.

ADHC providers, refer to Medicaid ADHC Provider Manual Chapter 9, Section 9.9- Incidents/Accidents/Complaints for details on reporting.

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 as well as the central records system. The report shall include:

- Recipient identifying information;
- Event information (including date, time, location, etc.) of the incident/accident;
- Circumstances surrounding the incident/accident;
- Description of the incident/accident (including any medical attention or law enforcement involvement, witnesses, etc.);
- Action taken to correct or prevent future occurrence of incident/accident; 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;

CHAPTER 7: COMMUNITY CHOICES WAIVER

**SECTION 7.10: INCIDENTS, ACCIDENTS AND
COMPLAINTS****PAGE(S) 3**

- Neglect;
- Exploitation;
- Extortion;
- Major injury;
- Major medical events;
- Death;
- Major behavioral incidents;
- Involvement with law enforcement;
- Loss or destruction of a recipient's home;
- 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 must report all suspected cases of abuse (physical, mental, emotional and/or sexual), neglect, 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 the appropriate authorities (See Appendix A for contact information).

For recipients ages 18 through 59 and emancipated minors, Adult Protective Services (APS) must be contacted. APS investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect, exploitation or extortion (See Appendix A for contact information).

For recipients age 60 or older, Elderly Protective Services (EPS) must be contacted. EPS investigates situations of abuse, neglect and/or exploitation of individuals age 60 or older (See Appendix A for contact information).

If the recipient needs emergency assistance, the worker must 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).

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SECTION 7.10: INCIDENTS, ACCIDENTS AND COMPLAINTS**PAGE(S) 3**

Internal Complaint Policy

Recipients must be able to file a complaint regarding their services without fear of reprisal. The support coordination agency, ADHC providers, and direct service providers must have a written policy to handle recipient complaints. In order to ensure that the complaints are efficiently handled, the agency/provider must comply with the following procedures:

- Each agency/provider must designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator must maintain a log of all complaints received. The complaint log must 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 must 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 agency/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.
- The agency/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 ADHC/direct 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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SECTION 7.11: SUPPORT COORDINATION**PAGE(S) 2**

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/reassessment;
 - Evaluation/Re-evaluation of LOC and need for waiver services
- Plan of Care development and revision:
 - Linkage to direct services and other resources; and
 - Coordination of multiple services among multiple providers.
- Follow-Up/Monitoring:
 - On-going assessment and mitigation of health, behavioral and health safety risks; and
 - Responding to recipient crisis;
- Critical Incident Management; and
- Transition/discharge and closure.

For additional details on Support Coordination responsibilities, procedures, and timelines, refer to Appendix B for the hyperlink to the *Office of Aging and Adult Services (OAAS) Waiver Procedures Manual*

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.

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SECTION 7.11: SUPPORT COORDINATION

The support coordinators are also responsible for reporting critical incidents. For additional details regarding reporting requirements, procedures, and timelines, refer to Appendix B for the hyperlink to the Critical Incident Reporting website.

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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 (see section 7.6 – Provider Requirements for a list of those particular services), with the exceptions of:

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

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APPENDIX A: CONTACT INFORMATION

CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
<p>OAAS State Office</p>	<p>Provides waiver assistance, clarification of waiver services, receives complaints regarding waiver services</p>	<p>Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031 1-866-758-5035</p>
<p>OAAS Regional Offices</p>	<p>Reviews and provides approval of waiver services, monitors support coordination services and offers providers technical assistance</p>	<p>http://ldh.la.gov/index.cfm/directory/category/141</p>
<p>Gainwell Technologies Provider Enrollment Unit</p>	<p>Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer.</p>	<p>Gainwell Technologies Provider Enrollment Unit P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm</p>
<p>Gainwell Technologies Provider Relations Unit</p>	<p>Office to contact to obtain assistance with questions regarding billing information and billing issues.</p>	<p>Gainwell Technologies Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Support/provider_supportindex.htm</p>
<p>Statistical Resources, Inc.</p>	<p>Agency to contact regarding LAWRRIS, CMIS, LaSRS, EVV, and PA Billing Issues.</p>	<p>11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501</p>
<p>Division of Administrative Law-Health and Hospitals Section</p>	<p>Office to contact to request an appeal hearing</p>	<p>Division of Administrative Law 1020 Florida Street Post Office Box 44033 Baton Rouge, LA 70802 Phone: (225) 342-1800 Fax: (225) 342-1813 http://www.adminlaw.state.la.us</p>

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APPENDIX A: CONTACT INFORMATION

<p>LDH Health Standards Section</p>	<p>Office to contact to report changes that affect provider license (e.g. Address Change, Change of Ownership, etc.)</p> <p>Office to contact when providers wish to request an informal hearing as the result of provider’s receipt of a statement of deficient practice or file a complaint against a provider by a recipient. a monitoring corrective action report or file a complaint against a provider agency</p>	<p>Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 1-800-660-0488</p>
<p>Medicaid Program Integrity</p>	<p>Office to contact to report Medicaid fraud.</p>	<p>Provider Fraud Hotline# 1-800-488-2917 Recipient Fraud Hotline# 1-888-342-6207 Provider Fraud Fax: (225) 216-6129 Recipient Fraud Fax: (225) 389-2610 http://ldh.la.gov/index.cfm/page/219</p>
<p>Adult Protective Services</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors.</p>	<p>1-800-898-4910</p>
<p>Elderly Protective Services</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older.</p>	<p>1-833-577-6532</p>
<p>Myers and Stauffer LC</p>	<p>Information about filing cost reports</p>	<p>http://www.mslc.com/Louisiana/HCBS.aspx</p>
<p>Adult Day Health Care Resources</p>	<p>Resources containing provider training and/or cost report training</p>	<p>http://ldh.la.gov/index.cfm/newsroom/detail/1573</p>

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APPENDIX A: CONTACT INFORMATION

Healthy Louisiana (Medicaid Managed Care Organizations)	Healthy Louisiana (previously called Bayou Health) is the way most of Louisiana's Medicaid and LaCHIP recipients receive health care services. In Healthy Louisiana, Medicaid recipients enroll in a Health Plan.	http://ldh.la.gov/index.cfm/subhome/6
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CHAPTER 7: COMMUNITY CHOICES WAIVER**APPENDIX B: FORMS/LINKS****PAGE(S) 3****FORMS/LINKS**

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://ldh.la.gov/assets/docs/OAAS/EmergencyPrep/Back-upStaffingPlanForm.pdf
Emergency Plan	http://www.ldh.la.gov/assets/docs/OAAS/EmergencyPrep/EmergencyPlanandAgreementForm.pdf
Rights and Responsibilities for Applicants/Participants of Home and Community-Based Services (HCBS) Waiver	http://www.ldh.la.gov/assets/docs/OAAS/publications/RightsRespon_Waivers.pdf
Community Choices Waiver (CCW) Service Log	http://www.ldh.la.gov/assets/docs/OAAS/publications/ServiceLogs/CCWServiceLogAndInstructions.pdf
Electronic Visit Verification (EVV)	http://ldh.la.gov/index.cfm/page/2751
Transition Services Form (TSF)	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf
Assistive Devices and Medical Supplies Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Assistive-Devices-and-Medical-Supplies-Form.pdf
Environmental Accessibility Adaptation (EAA) Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Environmental-Accessibility-Adaptation-Form.pdf
Nursing /Therapy Payment Authorization Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Nursing-Therapy-Payment-Authorization-Form.pdf
Monitored In-Home Caregiving (MIHC) Services Form	http://www.ldh.la.gov/assets/docs/OAAS/publications/Forms/Monitored-In-Home-Caregiving-Services-Form.pdf

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APPENDIX B: FORMS/LINKS

Form/Document/Website Name	Website Address
OAAS Critical Incident Reporting webpage	http://www.ldh.la.gov/index.cfm/newsroom/detail/1418?uuid=1295548571800
Louisiana Department of Health Office of Aging and Adult Services Community Choices Waiver Self-Direction Employer Handbook	http://www.ldh.la.gov/assets/docs/OAAS/Manuals/Self-Direction-Manual.pdf
Louisiana Department of Health Office of Aging and Adult Services Permanent Supportive Housing Policies and Procedure Manual	http://www.ldh.la.gov/assets/docs/OAAS/PSH/PSHManual.pdf
Community Choices Waiver Permanent Supportive Housing Housing Stabilization Services Housing Transition/Crisis Intervention Services Progress Note Form	http://www.ldh.la.gov/assets/docs/OAAS/publications/PSHPprogressNote.pdf
Request for Payment/Override Form	http://www.ldh.la.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://www.ldh.la.gov/assets/docs/OAAS/Manuals/dswflowchart.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://www.ldh.la.gov/index.cfm/newsroom/detail/2923
Support Coordination Transfer of Records Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Support-Coordination-Transfer-of-Records-Form.pdf

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APPENDIX B: FORMS/LINKS

Form/Document/Website Name	Website Address
Louisiana State Adverse Actions List Search and Office of the Inspector General	https://adverseactions.ldh.la.gov/SelSearch https://exclusions.oig.hhs.gov/
Federal System Award Management	https://www.sam.gov/SAM/
Medicaid Services Chart	http://www.ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

BILLING CODES

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

https://www.lamedicaid.com/provweb1/fee_schedules/CommChoWaiverBillingCodesRate_Current.pdf

CLAIMS RELATED INFORMATION

Hard copy billing of waiver services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. 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:

Gainwell Technologies
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.

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APPENDIX D: CLAIMS RELATED INFORMATION

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

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare / 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 ID 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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APPENDIX D: CLAIMS RELATED INFORMATION

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>	<p>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</p>
9b	Reserved for NUCC	Leave Blank.	
9c	Reserved for NUCC	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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APPENDIX D: CLAIMS RELATED INFORMATION

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.	For LA Medicaid “Other Source” is defined as the ordering provider or referring provider. Any provider entered as an ordering or a referring provider must be enrolled with LA Medicaid.
17a	Other ID#	Situational – Complete if applicable.	
17b	NPI#	Situational – If 17 or 17a is completed, this field is required.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	Additional Claim Information (Designated by NUCC)	Leave Blank.	
20	Outside Lab? \$Charges	Optional.	

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APPENDIX D: CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
24A	Date(s) of Service	Required -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
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	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
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	\$Charges	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	ID Qualifier	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 required when the seven-digit provider number is entered in the shaded portion.	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.	

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APPENDIX D: CLAIMS RELATED INFORMATION

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Locator #	Description	Instructions	Alerts
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.	
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	Other ID#	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#	Required – Enter the billing provider's 10-digit NPI number.	The 10-digit NPI Number must appear on paper claims.
33b	Other ID#	Required – Enter the billing provider's seven-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The seven-digit Medicaid Provider Number must 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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APPENDIX D: CLAIMS RELATED INFORMATION

SAMPLE WAIVER CLAIM FORM



WAIVER

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRI-CARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER <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					3. PATIENT'S BIRTH DATE (MM/DD/YY) 07/31/72					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
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"/>					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. EMPLOYMENT (Current/Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER									
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 due to me or to the party who accepts assignment below.) SIGNED					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undesignated physician or supplier for services described below.) SIGNED					14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM/DD/YY QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI					15. OTHER DATE QUAL MM/DD/YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. Z7689 B. C. D. E. F. G. H. I. J. K. L.					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
24. A. DATE(S) OF SERVICE From MM/DD/YY To MM/DD/YY B. PLACE OF SERVICE C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS E. F. CHARGES G. DAYS OF UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID.#					22. RESUBMISSION CODE ORIGINAL REF. NO.					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
25. FEDERAL TAX I.D. NUMBER SSN/EIN					26. PATIENT'S ACCOUNT NO. 1234					23. PRIOR AUTHORIZATION NUMBER Prior Auth #									
27. ACCEPT ASSIGNMENT? (For gmt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 165.00					29. AMOUNT PAID \$									
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.) Biller SIGNED 12/05/18 DATE					32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.					30. Rsvd for NUCC Use									
33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000					34. a. 1234509876 b. 1123456														

SAMPLE:
EXAMPLE
USE ONLY

1
2
3
4
5
6

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX D: CLAIMS RELATED INFORMATION

3/15/21

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX D: CLAIMS RELATED INFORMATION



HEALTH INSURANCE CLAIM FORM

WAIVER

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

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

1. MEDICARE MEDICAID TRI-CARE CHAMPVA HEALTH PLAN SECA OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
LOU, JANNIE

3. PATIENT'S BIRTH DATE
06 11 72

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
1234 ANYLANE

6. PATIENT RELATIONSHIP TO INSURED
Set Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE

9. CITY
MYTOWN

10. STATE
LA

11. CITY

12. STATE

13. ZIP CODE
70000

14. TELEPHONE (Include Area Code)
(225) 999-7777

15. ZIP CODE

16. TELEPHONE (Include Area Code)

17. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

18. IS PATIENT'S CONDITION RELATED TO:

19. INSURED'S POLICY GROUP OR FECA NUMBER

20. a. OTHER INSURED'S POLICY OR GROUP NUMBER
TPL CODE IF APPLICABLE

21. a. EMPLOYMENT? (Current or Previous)
 YES NO

22. a. INSURED'S DATE OF BIRTH
MM DD YY M F

23. b. RESERVED FOR NUCC USE

24. b. AUTO ACCIDENT?
 YES NO

25. c. RESERVED FOR NUCC USE

26. c. OTHER CLAIM ID (Designated by NUCC)

27. d. INSURANCE PLAN NAME OR PROGRAM NAME

28. 10d. CLAIM CODES (Designated by NUCC)

29. d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 YES NO

30. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

31. 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.

32. 18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

33. SIGNED: _____ DATE: _____ SIGNED: _____

34. 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
MM DD YY QUAL

35. 15. OTHER DATE
QUAL MM DD YY

36. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM MM DD YY TO MM DD YY

37. 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

38. 17a. _____

39. 17b. NPI

40. 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM MM DD YY TO MM DD YY

41. 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

42. 20. OUTSIDE LAB? YES NO \$ CHARGES

43. 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Please A-L to service line below (24E) ICD Ind. 0

44. A. Z7689 B. C. D. E. F. G. H. I. J. K. L.

45. 22. RESUBMISSION CODE ORIGINAL REF. NO.

46. 23. PRIOR AUTHORIZATION NUMBER
PA # IF APPLICABLE

47. 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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. ICD-9-CM I. ID. DUAL J. REFERRING PROVIDER ID. #

	A	B	C	D	E	F	G	H	I	J					
1	02	01	19	02	01	19	12		S5125	UN		A	90.00	30	NPI
2	02	09	19	02	09	19	12		S5125	UN		A	75.00	25	NPI
3															NPI
4															NPI
5															NPI
6															NPI

48. 25. FEDERAL TAX I.D. NUMBER SSN EIN

49. 26. PATIENT'S ACCOUNT NO.
1234

50. 27. ACCEPT ASSIGNMENT? (For gov't claims, see back)
 YES NO

51. 28. TOTAL CHARGE
\$ 165.00

52. 29. AMOUNT PAID

53. 30. Rev'd for NUCC Use

54. 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 hereof)
JANE DOE, MD

55. 32. SERVICE FACILITY LOCATION INFORMATION

56. 33. BILLING PROVIDER INFO & PH# (800) 233-3333
HERE FOR YOU WAIVER
700 MAIN ST
ANY TOWN, LA 70000

57. SIGNED: _____ DATE: 2/28/19

58. a. NPI b. 1326547895 c. 1987654

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PLEASE PRINT OR TYPE

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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.**

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX D: CLAIMS RELATED INFORMATION**PAGE(S) 16**

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.

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.

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX D: CLAIMS RELATED INFORMATION

SAMPLE WAIVER CLAIM FORM ADJUSTMENT



WAIVER

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRI-CARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER										<input type="checkbox"/> PICA 1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jayco, Travis					3. PATIENT'S BIRTH DATE (MM DD YY) 07 31 72					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					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: <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER									
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 is my dependent.) SIGNED: _____					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: _____					18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: _____									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Please A-L to service line below (I4E) ICD Ind:										22. RESUBMISSION CODE A 02 ORIGINAL REF. NO. 8347198798700									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										23. PRIOR AUTHORIZATION NUMBER Prior Auth #									
B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										F. \$ CHARGES 84.00									
25. FEDERAL TAX I.D. NUMBER 1234										26. PATIENT'S ACCOUNT NO. 1234									
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 84.00									
29. AMOUNT PAID \$										30. Rev'd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Billor SIGNED: _____ DATE: 12/17/18										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.									
33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000										a. 1234509876 b. 1123456									

SAMPLE USE ONLY

1
2
3
4
5
6

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

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CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX D: CLAIMS RELATED INFORMATION

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input type="checkbox"/> PICA												
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoO#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BULK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Programs in Item 1)							
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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
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"/>		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)					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) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME					
9. OTHER INSURED'S POLICY OR GROUP NUMBER					10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.					
b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC 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 _____					
d. INSURANCE PLAN NAME OR PROGRAM NAME					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 _____		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. _____ 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? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____					
21. 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. _____					22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____		23. PRIOR AUTHORIZATION NUMBER _____					
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 UNITS	H. FROST Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? For gov. claims, use below <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____		30. Rvd for NUCC Use	
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 _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____			33. BILLING PROVIDER INFO & PH # ()				

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Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website below for general information concerning topics relative to general claims filing.

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

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 (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) – The functions or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. Activities of daily living include bathing, dressing, eating, grooming, walking, transferring and/or toileting. 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 model adult day health care program 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.

Adult Day Health Care (ADHC) 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 individuals who: are age 65 or older, or aged 22-64 and have a physical disability, and meet nursing facility level of care requirements.

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

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX E: GLOSSARY

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Agency – An entity which delivers Medicaid support coordination services under an agreement with LDH/OAAS.

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)

Allowable Cost – Those expenses incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination; a legal proceeding in which the applicant/enrollee and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer (See “Fair Hearing”).

Applicant – An individual who is requesting Medicaid Waiver services.

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 meets nursing facility level of care and requires waiver services. The results are used to develop the Plan of Care and an Individualized Service Plan.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health is responsible for the administration of the Medicaid Program and is the administering agency for the OAAS Waiver programs.

Case Management – (See “Support Coordination”)

Centers 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 individuals who: are age 65 or older, or aged 21- 64 and have a physical disability, and meet the nursing facility level of care requirements.

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).

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX E: GLOSSARY

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 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 qualified waiver recipients to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to recipients. The EVV system will ensure that recipients are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Eligibility – The determination of whether or not a recipient qualifies to receive services based on meeting established criteria as set by LDH.

Enrollment – A determination made by LDH that a provider or agency meets the necessary requirements to participate as a Medicaid provider. This is also referred to as provider enrollment.

Exploitation – The illegal or improper use or management of the funds, assets or property, of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability 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)

Fair Hearing – A legal proceeding in which the recipient and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer.

Fiscal Intermediary – The contractor, managed by Medicaid, which processes claims, issues payments to providers and agencies, handles provider inquiries and complaints, provides training for providers.

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APPENDIX E: GLOSSARY**PAGE(S) 8**

Follow-Up – A core element of service delivery to the recipient that includes oversight and monitoring of the provision of services, ongoing assessment and mitigation of health, behavioral and personal safety risk, and crisis management.

Formal Services – Another term for professional and paid services.

Good Cause – An acceptable reason to change agencies or providers outside of the designated circumstances and timelines.

Health Standards Section (HSS) – A section of the Louisiana Department of Health responsible for the licensure and enforcement of compliance of those health care providers licensed by the Health Standards Section.

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 recipient's home or community as an alternative to institutional services to persons who meet nursing facility level of care. Waiver services are approved by CMS are limited to serving a specific number of individuals in accordance with the approved and available waiver opportunities.

Individualized Service Plan (ISP) – An individualized written plan of action to be completed and followed by providers to address the recipient's difficulties, health care needs, and services based upon his/her assessment. A comprehensive plan of care prepared in accordance with policies, procedures, and timelines established by Medicaid or by an LDH program office for reimbursement purposes may be substituted or used for the individual service plan for in-home providers.

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, but not limited to a hospital, nursing facility, or psychiatric hospital.

Internal 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.

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.

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX E: GLOSSARY

Licensure – A determination by the Health Standards Section that a provider meets the requirements of State law to provide health care and services.

Linkage – Act of connecting a recipient to a specific support coordination agency or service provider.

Long Term-Personal Care Services (LT-PCS) – A Medicaid state plan service which provides assistance with ADL and IADL as an alternative to institutional care to qualified Medicaid recipients who are age 21 or older and meet specific program requirements.

Louisiana Department of Health (LDH) - The state agency responsible for administering the state’s Medicaid Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and behavioral health services.

Louisiana Service Reporting System (LaSRS) – A secure modular web application developed by an LDH contractor to issue PAs and confirm post authorizations through EVV.

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 LDH or any other state agency (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).

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX E: GLOSSARY

Non-allowable costs – Costs that are not based on the reasonable cost of services covered under Medicare/Medicaid and are not related to the care of recipients.

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 intermediate, skilled nursing, and/or long term care for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within the Louisiana Department of Health that is responsible for the management and oversight of certain Medicaid home and community-based services waiver programs, state plan programs, adult protective services for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

OAAS Regional Office – One of nine administrative offices within the Office of Aging and Adult Services.

Office of Behavioral Health (OBH) – The office in LDH that is responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (OPH) – The office in LDH responsible for personal and environmental health services.

Office for Citizens with Developmental Disabilities (OCDD) – The office in LDH 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 – An approach used in the assessment and planning processes that considers an recipient’s personal experiences and preferences.

Plan of Care (POC) – A written person-centered plan developed by the recipient, his/her authorized representative and support coordinator based on assessment results. The plan specifies services to be accessed and coordinated by the support coordinator on the recipient’s behalf and includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Program of All-Inclusive Care for the Elderly (PACE) – Program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified

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APPENDIX E: GLOSSARY**PAGE(S) 8**

recipients age 55 and older in order to enhance their quality of life and allow them to continue to live in the community.

Progress Notes – Documentation of the delivery of services, activities, observations, and/or deviations from the POC of a recipient/recipient’s care to record important information as applicable.

Provider – An entity that delivers Medicaid services under a provider agreement with LDH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other LDH office. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other LDH funding source.

Provider Enrollment – See “Enrollment”.

Reassessment – See “Assessment”. The re-assessment is completed at least annually for waiver recipients and when a significant status change occurs in order to update the POC and/or ISP.

Recipient – An individual who has been certified for services through 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.

Request for Services Registry (RFSR) – A waiting list for the CCW program which contains the names and dates of requests of individuals applying for a CCW opportunity.

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

CHAPTER 7: COMMUNITY CHOICES WAIVER

APPENDIX E: GLOSSARY

in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)

Sexual Abuse – Any non-consensual sexual activity between a recipient and another individual. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the recipient to perform sex with any other person when recipient is not capable of or competent to refuse.

Support Coordination – 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 regardless of the funding source for these services. Activities also include assessment, Plan of Care development, service monitoring, critical incident management, and transition/discharge.

Support Coordinator – An individual who meets the required qualifications and who is employed by a Support Coordination Agency.

Transition – A shift from a recipient’s current services to another appropriate level of services, including discharge from all services.

Waiver Opportunity –

An offer made to an individual on the CCW Request for Services Registry. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.

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APPENDIX F: CONCURRENT SERVICES

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