



**RESIDENTIAL OPTIONS WAIVER
(ROW)
PROVIDER MANUAL**
Chapter Thirty-eight of the Medicaid Services Manual

Issued December 1, 2011

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 purpose of the Residential Options Waiver (ROW), a 1915(c) waiver, is to assist recipients of this service in leading healthy, independent, productive lives to the fullest extent possible and to promote the full exercise of their rights as citizens of Louisiana. Services are provided with the goal of promoting independence through strengthening the individual’s capacity for self-care and self-sufficiency. ROW is a service system centered on the needs and preferences of the recipients and supports the integration of recipients within their communities.

ROW provides an opportunity for individuals with developmental disabilities to transition from intermediate care facility/developmental disabilities or nursing home facility placement by creating community-based alternatives in home settings along with an array of comprehensive supports for those individuals with intensive and/or complex needs.

There is no age restriction as part of the ROW eligibility determination.

The objectives of the ROW are to:

- Promote independence for recipients through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of recipient safeguards;
- Offer an alternative to institutionalization;
- Support recipients and their families to exercise their rights and share responsibility for their programs regardless of the method of service delivery; and
- Offer access to services on a short-term basis that would protect the health and safety of the recipient if the family or other caregiver were unable to continue to provide care and supervision.

The Department of Health and Hospitals (DHH) Bureau of Health Services Financing (BHSF) is the single state Medicaid agency that maintains administrative and supervisory oversight of the ROW waiver. DHH designates the authority for implementation and programmatic oversight of the waiver to the Office for Citizens with Developmental Disabilities (OCDD)/Waiver Supports and Services (WSS) section through an interagency agreement.

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SECTION 38.0: OVERVIEW

Services are accessed through a single point of entry within OCDD. All waiver recipients choose their support coordination and direct service provider agencies through the freedom of choice process. All services must be prior authorized and delivered in accordance with an approved Plan of Care (POC), which is approved at the OCDD Regional Office/Districts/Authority level. Prior authorization is completed through an independent entity contracted by DHH.

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COVERED SERVICES

Residential Options Waiver (ROW) services must be provided in accordance with the service criteria defined in this section, the Centers for Medicare and Medicaid Services (CMS) application, state rule, and in conjunction with the recipient's approved Plan of Care (POC).

Recipients must be able to choose to receive services and supports from any provider in their region listed on the Freedom of Choice (FOC) listing. Direct service providers cannot offer FOC to recipients.

Under no circumstances may a service provider or direct service worker charge a recipient, their authorized representative, or their family member(s), or other support team members a separate transportation fee or any other fee for covered services.

ROW services are provided as a supplement to regular Medicaid State Plan services and natural supports, and should not be viewed as a lifetime entitlement or a fixed annual allocation. The average recipient expenditures for all waiver services shall not exceed the average Medicaid expenditures for Intermediate Care Facilities for Individuals with Developmental Disabilities, (ICF/DD) services.

All ROW recipients must receive a residential service (community living supports, companion care, host home, or shared living) and support coordination services. Other services are to be selected based on recipient need/want and individual budget.

Recipients must receive a residential service and support coordination at least once every 30 days.

All services must first be processed through Third Party Liability, Medicare, and private insurance prior to accessing ROW services except for the following:

- Support Coordination
- Companion Care
- Community Living Supports
- Host Home
- Shared Living
- One-Time Transitional Funding

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- Personal Emergency Response System
- Transportation-Community Access
- Supported Employment
- Day Habilitation
- Prevocational Services
- Environmental Adaptations

Providers are to meet Standards for Participation for Medicaid Home and Community-Based Waiver Services. (Refer to the Appendix C for the web address to access the Standards for Participation)

Support Coordination

Support coordination consists of the coordination of supports and services that will assist recipients who receive Residential Options Waiver services in gaining access to needed waiver and other Medicaid services, as well as needed medical, social, educational and other services, regardless of the funding source. Recipients/families choose a support coordination agency through the Freedom of Choice listing provided by the Medicaid data contractor upon acceptance of a waiver opportunity. The support coordinator is responsible for convening the person-centered planning team comprised of the recipient, recipient's family, direct service providers, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies to meet the recipient's needs and preferences. The support coordinator shall be responsible for the ongoing coordination and monitoring of supports and services included in the recipient's POC.

When recipients choose to self-direct their waiver services, the support coordinator is responsible for reviewing the Self-Direction Employer Handbook with each recipient who has elected this option for service delivery. Support coordinators will be available to recipients for on-going support and assistance in the following decision-making areas, as well as employer responsibilities:

- Recruiting, hiring, and terminating staff;
- Verifying employee qualifications;
- Orienting and instructing staff in duties;

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- Scheduling staff;
- Reviewing/approving employee timesheets;
- Conducting employee performance evaluations; and
- Reviewing/approving provider invoices.

Community Living Supports

Community Living Supports (CLS) is a residential option available to recipients who either have natural supports and/or who need very little support on an on-going basis. Based on their need of supports, recipients can either live with family members or reside independently in their own residence. The overall goal for each recipient is to obtain or maintain their level of independence, level of productivity, and involvement in the community as outlined in each recipient's approved POC. Individual specific goals are identified in the POC and provided by the recipient's direct support worker.

Supports provided include the following:

- Self-Help Skills:
 - Activities of daily living and self-care (i.e., bathing, grooming, dressing, nutrition, money management, laundry, travel training, and safety skills)
 - Intended to increase level of independence
 - Travel-training to community activities/locations (not intended to be used when the recipient is learning to go to and from a vocational setting)
- Socialization Skills:
 - Appropriate communication with others, both verbal and nonverbal (i.e., manners, making eye contact, shaking hands, and behavior)
 - Intended to increase involvement in the community (i.e., church membership, voting, participation in sports, and volunteering)
- Cognitive and Communication Tasks:

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- Learning activities
(i.e., attention to task, self-control, verbal/nonverbal communication, and interpersonal communication-verbal/nonverbal cues)
- Intended to increase level of understanding and to communicate more effectively
- Acquisition of Appropriate, Positive Behavior:
 - Appropriate behavior
(i.e., non-aggression and appropriate social interaction)
 - Intended to increase socially appropriate behavior

Community Living Supports providers are to work collaboratively with the recipient's natural supports, support coordinator, vocational provider, and/or professional provider to identify specific training opportunities based on the recipient's daily routine, need, and level of interest. Training components can include self-help skills, socialization skills, cognitive and communication skills, and acquisition of appropriate/positive behavior.

Community Living Supports (Shared Supports)

Community Living Supports may be shared by up to three recipients who may or may not live together and who have a common direct service provider. In order to share Community Living Supports, recipients and their family/legal guardians must agree. The health and welfare of each recipient must also be assured. Shared staff must be reflected in each recipient's POC and be based on an individual basis. A shared rate is billed when recipients share Community Living Supports.

When this service is provider managed, the provider has 24 hour responsibility to deliver back-up and emergency staff to meet unpredictable needs of the recipient in a way that promotes maximum dignity and independence while enhancing supervision, safety and security.

When the self-directed option is utilized the recipient must have an individualized back-up plan and evacuation plan both of which must be submitted with the POC for review and approval. The direct support workers must meet minimum qualifications.

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Transportation

The cost of transportation is built into the Community Living Supports rate and must be provided when it is integral to Community Living Services. Transportation-Community Access service can be utilized by Community Living Support recipients as long as Transportation-Community Access is not billed at the same time as Community Living Supports.

Service Units and Limitations

- Service Unit: 15 minutes
- Payment does not include room and board, maintenance, upkeep, and/or improvement of the recipient's or family's residence;
- The recipient and Community Living Supports staff may not live at the same residence;
- Staff providing services may not sleep during billable hours of Community Living Supports;
- Community Living Supports may not be provided in a licensed respite care center;
- Provider may not bill for Community Living Supports for the same time on the same day as respite services;
- Community Living Supports are not available to individuals receiving Shared Living Services, Host Home Services, or Companion Care Services (the same type of supports that Community Living Supports provides are integral to and built into the rate for these three services, and prevents duplication of services)
- Payment will not be made for travel training to vocational services;
- Community Living Supports cannot be provided or billed for at the same time on the same day as:
 - Supported Employment,
 - Day Habilitation, or
 - Prevocational Services.

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- Transportation-Community Access services may not be provided at the same time as Community Living Supports services.

Host Home Services

Host Home services is a residential option available to recipients who wish to live in a family setting when residing with their immediate family is not an option. Host Home services are available to recipients of any age and take into account individual compatibility which includes individual interests, age, privacy needs, and supervision/support needs. The Host Home Family provides the recipient with a welcoming, safe, and nurturing family environment. In addition, the recipient is provided any assistance needed with activities of daily living and support. Community activities identified in the recipient's POC are also encouraged and supported.

Place of Service

The primary source of service is considered to the Host Home Family residence. The Host Home Family must own, rent, or lease their place of residence. The Host Home Family can also provide supports and services in the community setting as indicated in the recipient's POC.

Service Units and Limitations

- Service Unit is a per diem rate based on the recipient's Inventory for Client and Agency Planning (ICAP),
- Children eligible for Title IV-E services are not eligible for Host Home services;
- Regardless of the funding source, a Host Home Family shall not have more than two people for whom the Host Home Family is receiving compensation, (regardless of funding source);
- Must not allow more than three persons unrelated to the principal caregiver to live in the home;
- Payment is not made for room and board;
- Separate payment will not be made for the following services:
 - Community Living Supports;
 - Respite Care Services-Out of Home;

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- Shared Living;
 - Companion Care;
 - Environmental Accessibility Adaptations; and
 - One-Time Transitional Services.
- The Host Home Family may not be the owner or administrator of the Host Home Provider agency to prevent conflict of interest

Companion Care Services

Companion Care Services is a residential option available to recipients who do not typically require 24-hour supports. Recipients in this residential option receive supports provided by a companion who lives in the residence as the recipient's roommate. The companion provides supports and assistance as identified in the recipient's POC. An agreement is developed between the recipient and the companion that outlines the specifics of the arrangement. This residential option is most feasible for adults (age 18 and older) who either own their own home or who rent. Companion Care Services are designed to support recipients who are able to manage their own household with the need for only limited supports.

Companion Care Services:

- Focus on assisting the recipient to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community;
- Provide assistance with the activities of daily living as specified in the recipient's POC;
- Provide assistance with community access and coordination of transportation, including medical appointments;
- Provide assistance/support consistent with the recipient's goals as identified in the recipient's POC;
- Are provided by a companion (roommate) who:
 - Must be at least 18 years of age;
 - Must live with the recipient;
 - Must purchase personal food and personal care items; and

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- Is a contracted employee of the provider agency and is paid a flat daily rate to provide limited, daily direct services as negotiated with the recipient

- Include a daily pre-arranged schedule for supports in addition to the companion being accessible by telephone 24 hours a day for crisis support on short notice to ensure the health and safety of the recipient.

Recipient/Companion Agreement

The Recipient/Companion Agreement is developed between the recipient and companion to identify the specific type(s) of assistance the recipient needs both in the home setting and in the community that the companion is to provide. The agreement also includes responsibilities which are to be shared by the recipient and companion. It also includes a typical weekly schedule.

The provider assists by facilitating the development of the written agreement. The agreement then becomes part of the recipient's POC. Revisions to the Recipient/Companion Agreement must be facilitated by the recipient's provider and approved by the POC team. Revisions may occur at the request of the recipient, the companion, the provider or the recipient's support team.

Place of Service

Companion Care services are delivered in the recipient's home. The companion also supports the recipient by assisting the recipient in the community as indicated in the recipient's POC and in the Recipient/Companion Agreement.

Service Units and Limitations

- Service Unit is a per diem rate based on the recipient's ICAP

- Separate payment will not be made for:
 - Respite Care Services;
 - Community Living Supports;
 - Host Home; and
 - Shared Living Services.

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Shared Living Services

Shared Living Services are chosen by the waiver recipient and developed in accordance with the recipient's goals and wishes regarding compatibility, interests, age and privacy. Services and supports are provided according to the recipient's POC to assist in acquiring, retaining and improving the self-care, adaptive and leisure skills needed to reside successfully in a shared living setting within the community. The Shared Living Provider is responsible to provide overall assurances for the health, safety and welfare of the recipient.

A Shared Living Provider delivers supports to include 24-hour staff availability and responsibilities as required in each person's approved POC, daily schedule and health and welfare needs related to the residential setting. This service includes assistance with all activities of daily living (ADLs) as needed and indicated in the POC.

Shared Living Services may include the "Conversion Option" or the "New/Non-Conversion Option":

- Conversion Option:
 - Providers of existing ICF/DD group or community homes (up to 8 beds as of 7/01/09) permanently close one or more homes and surrender the ICF/DD Medicaid license for each home closed;
 - The certified and enrolled beds which were in the ICF's/DD are closed are used to fund new community-based waiver opportunities (slots) through Money-Follows-the-Person;
 - Providers are able to provide Shared Living services up to a maximum of 4 recipients; and
 - Recipients are able to choose any ROW residential option including Shared Living.
- Non-Conversion (New) Option:
 - Providers are able to provide Shared Living services for up to a maximum of 3 recipients; and
 - Funding for Shared Living (New) services are legislatively funded waiver opportunities (slots).

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ICF/DD Conversion

Provider begins agency planning for the conversion by involving the individuals who are currently residing in the ICF/DD and their families/legal representatives. The provider will discuss options with the individuals, family members, and primary correspondents. The provider completes a Conversion Proposal and submits to OCDD State Office;

The OCDD State Office and the Bureau of Health Services Financing (BHSF) evaluate the Conversion Proposal and return a response to the provider regarding the Determination of Conversion Proposal. If the Conversion Proposal is approved, the provider will be sent the Conversion Agreement; and the number of ROW opportunities being made available.

The provider enters into a Conversion Agreement which includes:

- Closure of ICF/DD beds and
- Surrender of ICF/DD license;

Individuals are offered a ROW opportunity and Support Coordination Freedom of Choice. Each individual has the option of choosing to continue to reside in an ICF/DD or to accept the ROW opportunity.

If an individual chooses to accept a ROW opportunity, the Support Coordinator will assist the individual with the Freedom of Choice selection of a provider. The individual can choose to remain with the current provider or select another provider.

Place of Service

Shared Living services are delivered in the recipient's place of residence and in the community as indicated in the recipient's POC.

- A recipient may live in a residence that they own, rent, or lease. Environmental modifications are available to the recipient in this setting.
- A recipient may live in a residence that the provider owns or leases. Environmental modifications are not available to the recipient in this setting. Providers are responsible for making modifications.

Transportation

The cost of transportation is built into the Shared Living rate. As a result, Transportation-Community Access is not available to recipients receiving Shared Living services.

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Service Units and Limitations

Service Unit is per diem with the rate based on the recipient's ICAP.

Recipients receiving Shared Living services are not eligible to receive:

- Respite Care Services;
- Companion Care;
- Host Home;
- Community Living Supports; or
- Transportation - Community Access.

Recipients who live in a residence that is owned or leased by the provider are not eligible to receive Environmental Modification services. Payments are not made for room and board, the cost of home maintenance, upkeep or improvements.

Respite Care Services – Out of Home

Center-based respite care is a service provided to recipients unable to care for themselves and is furnished on a temporary/short-term basis due to the absence or need for relief of those persons normally providing unpaid care. This service must be provided in a licensed center-based respite care facility. Services are provided according to a POC that takes into consideration the specific needs of the person.

Participation in community activities is to be available in accordance with the recipient's approved POC. Transportation to and from these activities are also included in Respite Care Services-Out of Home. As a result, recipients are able to continue activities they typically engage in which include school attendance, school related activities, or other activities the recipient would attend if he/she were in their typical residential setting.

Service Units and Limitations

Respite Care Services - Out of Home:

- Service unit is 15 minutes;

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- Limited to 720 hours per recipient, per POC year. The process for approving hours in excess of 720 hours must go through the established approval process with proper justification and documentation; and
- Cannot be provided in a private residence.

Since Shared Living, Host Home and Companion Care Services already include in their rate the cost of providing relief for individuals normally providing unpaid care, Respite Services-Out of Home are not provided to recipients receiving:

- Shared Living Services;
- Host Home Services; or
- Companion Care Services.

Personal Emergency Response System (PERS)

A Personal Emergency Response System (PERS) is a rented electronic device that enables recipients to secure help in an emergency. PERS services are available to recipients who meet the following criteria:

- Have a demonstrated need for quick emergency back-up,
- Are unable to use other communication systems as the systems are not adequate to summon emergency assistance, or
- Do not have 24 hour direct supervision.

The recipient may wear a portable "help" button to allow for mobility. The PERS is connected to the person's phone and programmed to signal a response center to secure help in an emergency once the "help" button is activated. The response center is staffed by trained professionals.

PERS services include the initial installation of the equipment, training for the recipient in the use of the device, rental of the device, and monthly maintenance fees.

The monthly fee, regardless of the number of units in the household, shall include the cost of maintenance and training the recipient to use the equipment.

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Reimbursement will be made for a one time installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS. (See Appendix E for Rate and Billing Code information)

Service Units and Limitations

- Service unit is initial installation and monthly service;
- Reimbursement will be made for an installation fee for the PERS unit; and
- Coverage of the PERS is limited to the rental of the electronic device; a monthly fee will be paid for the maintenance of the PERS.

One - Time Transitional Services

One – Time Transitional Expenses are non-reoccurring set-up expenses for recipients, age 18 and older, who are transitioning from an Intermediate Care Facility for People with Developmental Disabilities (ICF/DD) to their own home or apartment in the community of their choice.

The recipient's home is defined as the recipient's own residence and does not include the residence of any family member or a Host Home.

Allowable transitional expenses include the following:

- The purchase of essential furnishings such as
 - Bedroom and living room furniture,
 - Table and chairs,
 - Window blinds,
 - Eating utensils,
 - Food preparation items, and
 - Bed/bath linens.

NOTE: Purchased items belong to the recipient and may not be misused or sold under any circumstances.

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- Moving expenses required to occupy and use a community domicile,
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy, and
- Nonrefundable security deposits and set-up fees (i.e. telephone, utility, heating by gas) which are required to obtain a lease on an apartment or home.

This service shall only be provided by the Louisiana Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD) with coordination of appropriate entities.

Service Units and Limitations

- There is a one-time, life time maximum of \$3,000 per recipient;
- Service expenditures must be prior authorized and are time limited;
- Cannot be used for refundable security deposits;
- Security deposits are not to include rental payments;
- May not be used to pay for furnishings or setting up living arrangements for:
 - Residences of any family member;
 - Persons receiving Host Home Services; or
 - Payment for housing or rent.

Environmental Accessibilities Adaptations

Environmental Accessibilities Adaptations include physical adaptations to the recipient's home or vehicle which are necessary to ensure the health, welfare and safety of the recipient, or which enable the recipient to function with greater independence in the home. Prior to the recipient receiving any environmental adaptation, an evaluation is to be completed by an occupational therapist and/or a physical therapist. The therapist is to assess for need and type of device/adaptation and are to make a recommendation regarding the specific environmental adaptation necessary to address the identified needs of the recipient. All environmental accessibilities adaptations are to be included in the recipient's POC.

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Home Adaptations

Home Accessibility Adaptations may include:

- Performance of necessary assessments in addition to occupational therapy/physical therapy evaluations that may be necessary to determine the types of modifications that are necessary;
- Installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient;
- Training the recipient and provider in the use and maintenance of the adaptation;
- Repair of all equipment and/or devices, including battery purchases and other reoccurring replacement items that contribute to the ongoing maintenance of the adaptation(s); and
- Provision of service contracts and other warranties from manufactures and providers related to the environmental adaptations.

Place of Service

Provided at the recipient's home and may not be furnished to adapt living arrangements that are owned or leased by waiver providers; and may be applied to rental or leased property only with the written approval of the landlord and approval of OCDD.

Service Units and Limitations

Service unit is per item/service. All adaptations must meet all applicable standards of manufacture, design, and installation.

Home modification funds are not intended to cover basic construction cost. Waiver funds may be used only to cover the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation must pay for a specific approved adaptation;

Funds may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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Funds may not include modification which adds to the total square footage of the home except when the additional square footage is necessary to make the required adaptations work. (For example, if a bathroom is very small and a modification cannot be done without increasing the space).

When new construction or remodeling is involved, coverage is available only for the difference between the cost of regular construction and the cost of specialized construction for the person with the disability.

Adaptations may not include modifications to the home which are of general utility, and are not of direct medical or remedial benefit to the individual (such as flooring, roof repair, central air conditioning, hot tubs, swimming pools, exterior fencing, or general home repair and maintenance); and cannot be paid for in provider-owned settings, such as Host Homes and provider-owned or leased Shared Living settings.

A written, itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification must be obtained and submitted to the OCDD Regional Waiver Office for prior authorization. The OCDD Regional Waiver Office must approve the "Environmental Modifications Job Completion Forms" (Form-PF-01-010). Upon completion of the work and prior to payment, the provider shall give the recipient a certificate of warranty for all labor and installation, and all warranty certificates from manufacturers. The warranty for labor and installation must cover a period of at least six (6) months. Payment will not be authorized until written documentation which demonstrates that the job has been completed to the satisfaction of the recipient has been received by the support coordinator. The Environmental Accessibility Adaptation, must be accepted by the recipient, fully delivered, installed, operational, and reimbursed in the current POC year in which it was approved. The support coordinator must contact the OCDD Regional Waiver Office before approving modifications for a recipient leaving an ICF/DD.

Vehicle Adaptations

Vehicle Adaptations are modifications to an automobile or van that is the recipient's primary means of transportation in order to accommodate their special needs. Vehicle Adaptations must be specified in the POC as necessary to enable the recipient to integrate more fully into the community and to ensure the health, welfare and safety of the recipient.

Vehicle Adaptations may include:

- The performance of necessary assessments in addition to occupational therapy/physical therapy evaluations to determine the types of modifications that are necessary;

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- A lift or other adaptations to make the vehicle accessible to the recipient or to make the vehicle accessible for the recipient to drive;
- Training the recipient and provider in the use and maintenance of the adaptation;
- Repair of all equipment and/or devices, including battery purchases and other reoccurring replacement items that contribute to the ongoing maintenance of the adaptation(s); and
- Provision of service contracts and other warranties from manufactures and providers related to the Environmental Adaptations.

Service Units and Limitations

- Service unit is per service;
- Payment may not be made to adapt vehicles that are owned or leased by paid caregiver or providers of waiver services;
- The following vehicle adaptations are excluded:
 - Modifications which are of general utility and are not of direct medical or remedial benefit to the recipient;
 - Purchase or lease of a vehicle; and
 - Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
- Car seats not considered a vehicle adaptation.

A written, itemized, detailed bid must be obtained and submitted to the OCDD Regional Waiver Office for prior authorization. The OCDD Regional Waiver Office must approve the "Environmental Modifications Job Completion Forms." Upon completion of the work and prior to payment, the provider shall give the recipient a certificate of warranty for all labor and installation, and all warranty certificates from manufacturers. The warranty for labor and installation must cover a period of at least six (6) months. Payment will not be authorized until written documentation which demonstrates that the job has been completed to the satisfaction of the recipient has been received by the support coordinator. The Environmental Accessibility Adaptation, must be accepted by the recipient, fully delivered, installed, operational, and reimbursed in the current POC year in which it was approved.

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The support coordinator must contact the OCDD Regional Waiver Office before approving modifications for a recipient leaving an ICF/DD.

Assistive Technology/Specialized Medical Equipment and Supplies

Assistive Technology/Specialized Medical Equipment and Supplies (AT/SMES) include items, devices, and equipment that are used to increase, maintain, and/or improve the functional capability of the recipient. AT/SMES include items that are necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; any necessary durable and non-durable medical equipment not available under the State Plan to address recipient functional limitations; and necessary medical supplies which are not available under the State Plan.

Prior to the recipient receiving any Assistive Technology device, an evaluation is to be completed by an occupational therapist and/or a physical therapist. The therapist is to assess for need and type of device and are to make a recommendation regarding the specific Assistive Technology device necessary to address the identified needs of the recipient. AT/SMES are to be included in the recipient's POC.

Assistive Technology/Specialized Medical Equipment and Supplies includes:

- Evaluation of the assistive technology needs of a recipient, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the recipient in the customary environment of the recipient in addition to occupational therapy/physical therapy evaluations;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for the recipient;
- Training or technical assistance for the recipient, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the recipient;
- Training or technical assistance for professionals or other individuals who provide services to, employ, or who are otherwise substantially involved in the major life functions of the recipient;
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the POC;

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- Provision of service contracts and other warranties from manufactures and providers related to the AT/SMES; and
- Repair of all items purchased, including battery purchases and other reoccurring replacement items that contribute to ongoing maintenance of these devices.

Requirements

All equipment, accessories and supplies must meet all applicable manufacture, design and installation requirements.

Place of Service

AT/SMES equipment, accessories and supplies are delivered in the recipient's home and in the community as applicable. Training is to be provided at the recipient's home, at sites where the recipient receives waiver services and/or at other places where the recipient engages in activities in his/her community where the devices will be utilized. Place of service must be in accordance with the recipient's POC.

Limitations

Excluded are those durable and non-durable items that are available under the Medicaid State Plan. Support coordinators shall pursue and document all alternate funding sources that are available to the recipient before submitting a request for approval to purchase or lease assistive technology/specialized medical equipment and supplies.

To avoid delays in service provisions/implementation, the support coordinator should be familiar with the process for obtaining assistive technology/specialized medical equipment and supplies or durable medical equipment (DME) through the Medicaid State Plan.

Excluded are those equipment and supplies that are of general utility or maintenance and are not of direct medical or remedial benefit to the recipient, such as:

- Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.),
- Daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, Q-tips, etc.),
- Rent subsidy,
- Food, bed covers, pillows, sheets etc.,
- Swimming pools, hot tubs etc.,

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- Eye exams,
- Athletic and tennis shoes,
- Automobiles,
- Van lifts for vehicles that do not belong to the recipient or his/her family,
- Adaptive toys or recreation equipment (swing set, etc.),
- Personal computers and software,
- Exercise equipment,
- Taxi fares, intra and interstate transportation services, and bus passes,
- Pagers, including monthly service,
- Telephones, including mobile telephones and monthly service, and
- Home security systems, including monthly service.

Transportation – Community Access Services

Transportation – Community Access Services is available to recipients who are receiving Community Living Supports and Companion Care. This transportation service is available to assist the recipient in increasing their level of independence, productivity, and community inclusion.

Transportation – Community Access Services provides the recipient with a means of access to community activities, community services, and community resources as outlined in the recipient's POC.

Place of Service

Transportation – Community Access Services is delivered from the recipient's home to the community and back to the recipient's home.

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Service Units and Limitations

- Service unit is “one-way,” limited to three round trips per day with an annual limit of 264 “one-way” units;
- All trips have to be in accordance with and included in the POC;
- All trips must be clustered together for geographic efficiency;
- Greater than three trips per day will require prior approval from the OCDD Regional Office/Authority/District;
- Whenever possible, family, neighbors, friends, or community agencies which can provide transportation into the community are to do so without charge;
- Whenever possible, public transportation or the most cost-effective method of transport will be utilized, including public transportation;
- Shall not replace transportation services to medically necessary services under the State Plan and transportation services provided as a means to get to and from school;
- Not to be used to transport the recipient to any day habilitation, pre-vocational, or supported employment services;
- May not be provided at the same time on the same day as Community Living Supports;
- Not available to recipients receiving Shared Living Services or Host Home Services; and
- Provider is limited to providing service to three recipients.

Professional Services

Professional services are provided to the recipient based on individual need and must be specified in the recipient’s POC. Professional services available include: Occupational Therapy, Physical Therapy, Speech Therapy, Nutrition/Dietary, Social Work and Psychology. The specific type of professional service delivered must be consistent with the scope of the license held by the professional. Service intensity, frequency, and duration may be short-term, intermittent, or long-term and is determined by individual need.

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Recipients under age 21 are to access professional services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program prior to accessing professional services through ROW.

Professional services may only be furnished and reimbursed through ROW when the services are not covered under the Medicaid State Plan and after Third Party Liability.

The specific professional service may be utilized to:

- Assist in increasing the recipient's independence, participation and productivity at home, at vocational/employment setting and/or in the community;
- Perform assessments and/or re-assessments and provide recommendations, treatment and follow-up;
- Provide information to the recipient, family, and support team to assist in the planning and implementation of the recipient's POC;
- Provide training to family/caregivers regarding recipient skill acquisition and support techniques (medical and behavior supports);
- Provide necessary therapy to the recipient as indicated in the POC;
- Provide consultative services and recommendations;
- Provide counseling for the natural, adoptive, or host home family members with the goal of developing and maintaining healthy, stable relationships between the recipient and family/support; and
- Intervene/stabilize a crisis situation (behavioral or medical) that could result in the loss of home and community-based services; close coordination between the professional(s) and community medical/therapy supports is provided through the support coordinator.

Service Units and Limitations

- Service unit is 15 minutes, and
- The recipient must be present for professional services to be billed.

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Nursing Services

Nursing services are medically necessary services that are ordered by a physician and are provided by a registered nurse or licensed practical nurse within the scope of the state's Nurses Practice Act. Nursing services are available to recipients as medically indicated and must be in the recipient's POC.

Nursing services may include assessments, health related training/education for recipients and caregivers. Nursing services address the healthcare needs of the recipient and may include both prevention and primary care activities.

Nursing services must be included in the recipient's POC along with the following documentation:

- Physician's order;
- Physician's letter of medical necessity;
- 90-L and 485;
- Individual nursing service plan;
- Summary of medical history; and
- Skilled nursing checklist.

The nurse must submit updates every 60 days and include any changes in the recipient's needs and/or any physician's orders.

Service Units and Limitations

- Service unit is 15 minutes;
- Assessment services are offered on an individual basis only and must be performed by a Registered Nurse; and
- Health related training/education service is the only nursing service which can be provided to more than one recipient simultaneously. In this instance, the cost of the service is allocated equally among all recipients receiving the health-related training/education.

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Place of Service

Services can be provided in the recipient's home, vocational/employment setting, or in the community.

Dental Services

Dental services include the following services: diagnostic, preventative, restorative, endodontic, periodontic, removable prosthodontic, maxillo facial prosthetic, fixed prosthodontic, oral and maxillo facial surgery, orthodontics, and adjunctive general. Recipients who need denture services are to first use the denture services provided in State Plan. Recipients under the age of twenty-one are to access dental services through EPSDT.

Adult Dental Procedures

Routine examinations, cleaning, and x-rays can be included on the recipient's POC and provided after going through the POC approval process. If it is determined during the planning process that the recipient may require additional dental procedures, an estimated monetary amount can be included in the recipient's planning budget to ensure the recipient will be able to access dental services (specific dental codes and rates can be found at www.lamedicaid.com). After approval of the POC, the recipient will schedule an appointment with a Medicaid enrolled dentist. The dental providers will determine the need for any additional dental procedures. The Dental Provider will follow current Medicaid approval procedures including sending the dental procedure recommendation(s) to LSU School of Dentistry for review.

After review, the LSU School of Dentistry will approve or deny the recommendation. Approved procedures will be put in a "pending" status and forwarded to fiscal intermediary agency then on to the Medicaid data contractor for review. If funding is available in the recipient's approved POC budget, the Medicaid data contractor will approve the procedure(s) and forward a letter to the dental provider. If funding is not available in the recipient's approved POC budget, Medicaid data contractor will not approve the procedure(s).

Service Units and Limitations

- Service unit is per service;
- The recipient may obtain denture services through ROW, but only after exhausting the Medicaid State Plan Denture Program; and
- Dental services are not provided to children (under the age of 21). Children are able to access dental services through State Plan (EPSDT).

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Supported Employment

Supported Employment is intensive, ongoing supports and services necessary for a recipient to achieve the desired outcome of employment in a community setting where the majority of the persons employed do not have disabilities. Recipients may require long-term supports where natural supports do not meet their needs.

Supported Employment options:

- Individual placement: An employment specialist (job coach) assists the recipient in locating and securing employment, provides training and support to the recipient, and then gradually reduces time and assistance at the worksite dependent upon the recipient's individual needs.
- Micro-enterprise: Services that assist a recipient to develop and operate a business. This assistance consists of: (a) assisting the recipient to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing as well as other types of supports related to the development and start-up of a business; (c) identification of supports necessary for the recipient to operate the business; and, (d) ongoing assistance, counseling and guidance after the business has started.
- Mobile Work Crew: A group of eight or fewer recipients employed as a team who typically work in a variety of locations with the support of an employment specialist (job coach).
- Enclave: A group of eight or fewer recipients employed as a team who typically work in a particular work setting with the support of an employment specialist (job coach).

Initial Job Support and Retention

Support provided to the recipient on or off the job site by provider staff consisting of one or more of the following activities:

- On-the-job support that ensures the recipient is able to obtain the necessary skills needed for the job and meet the employer's expectations;
- Personal care assistance with activities of daily living (as needed); and

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- Travel training for the purpose of teaching the recipient how to use transportation services.

Transportation

Transportation for Supported Employment services has a specific procedure code for billing purposes. Whenever possible, natural supports are encouraged to provide transportation. Under no circumstances can a provider charge a recipient, his/her responsible representative(s), family members or other support team members a separate transportation fee. Transportation providers must carry \$1,000,000 liability insurance on the vehicles used in transporting the recipients.

Service Units and Limitations

- Individual placement – must have one hour or more spent on the job site or training with the job coach per recipient per day;
- Micro-enterprise – must have one hour or more spent on the job site or training with the job coach per recipient per day;
- Mobile Work Crew – must have 2.5 hours up to 5 hours for the first unit; 5 hours and over for the second unit spent at the job site per recipient per day; and
- Enclave – must have 2.5 hours up to 5 hours for the first unit; 5 hours and over for the second unit spent at the job site per recipient per day.

For mobile crews and enclaves, a total of two units may be billed if the recipient spends a minimum of 5 hours spent at the service site. No rounding up of hours, such as 4.5 equals 5 hours is allowed. Any time less than the minimum number of hours of service specified above for any model is not billable or payable.

Time spent in transportation to and from the jobsite shall not be included in the total number of Support Employment service hours provided per day, however, travel training for the purpose of teaching the recipient how to use transportation services may be included in determining the total number of service hours, but for only the period of time specified in the recipient's POC.

The provider is responsible for all transportation from the agency to all work sites related to the provision of services. Transportation to and from the service site is offered and billable as a component of Supported Employment. Transportation is payable only when a supported employment service is provided on the same day.

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When Supported Employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required by the recipient as a result of their disabilities, but payment will not be made for the supervisory activities rendered as a normal part of the business setting.

Payments are not billable or payable for vocational training that is not directly related to the recipient's supported employment as indicated in the POC.

Exclusions include incentive payments, subsidies, or unrelated vocational training expenses including:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; or
- Payments that are passed through to recipients of supported employment programs.

Recipient may receive more than one type of vocational /habilitation service per day as long as it meets the billing criteria and the requirements for the minimum time spent at the site.

Billing for multiple vocational/habilitative services at the same time is prohibited. Supported Employment services may not be billed for on the same day at the same time as the following:

- Community Living Supports,
- Professional Services (except those direct contacts needed to develop a behavioral management plan or other therapeutic plan), and
- Respite Care Services - Out of Home.

Supported Employment services are not available to individuals who are eligible to participate in programs under the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA).

Prevocational Services

Prevocational services are prevocational activities designed to assist a recipient in acquiring and maintaining basic work-related skills necessary to acquire and retain employment and indicated in the POC.

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Prevocational services include real and simulated vocational tasks to determine vocational potential and level of assistance to develop the required skills. Types of prevocational activities include learning to following instructions, attention to task, task completion, problem solving, and safety skills. Prevocational activities focus on teaching general skills rather than teaching a specific job task and are based on the recipient's vocational preferences and goals. Progress for each activity is to be routinely reviewed and evaluated with revisions made as necessary.

Prevocational services are provided to persons who:

- Will be able to work in a paid work setting, and
- Need intensive ongoing support to perform in a paid work setting.

In the event recipients are compensated when performing prevocational activities, the following must be adhered to:

- Pay must be in accordance with the United States Fair Labor Standards Act of 1985.
- If a recipient is paid in excess of 50% of minimum wage:
 - The provider must conduct at a minimum:
 - Conduct 6 month formal reviews to determine the suitability of this service rather than Supported Employment services;
 - Make a recommendation to transition the recipient to a more appropriate vocational opportunity; and
 - Provide the support coordinator with documentation of both the productivity time studies and documented reviews of current placement feasibility.

Transportation

Transportation for Prevocational services has a specific procedure code for billing purposes. Whenever possible, natural supports are encouraged to provide transportation. Under no circumstances can a provider charge a recipient, his/her responsible representative(s), family members or other support team members a separate transportation fee. However, the provider is responsible for all transportation from the agency to all sites related to Prevocational services. Transportation is payable only when a Prevocational service is provided on the same day.

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Transportation providers must carry \$1,000,000 liability insurance on the vehicles used in transporting the recipients.

Service Units and Limitations

- Services are to be furnished on a regularly scheduled basis for one or more days per week based on a 2.5 hour unit of service.
- Must have 2.5 hours up to 5 hours for the first unit; 5 hours and over for the second unit spent at the service site per recipient per day.
- A total of two units may be billed if the recipient spends a minimum of 5 hours spent at the service site.
- Any time less than 2.5 hours of service is not billable or payable.
- No rounding up of hours, such as 4.5 equals 5, is allowed.
- Services shall be limited to no more than 8 hours a day, 5 days a week.
- Time spent in transportation to and from the program for the purpose of training the recipient on the use of transportation services may be included in the number of hours of services provided per day for the period of time specified in the POC, but when this occurs, providers must not also bill for the transportation component as it is included in the rate for the number of service hours provided.
- Recipient may receive more than one type of vocational/habilitation service per day provided the billing criteria and the requirements for the minimum time spent on site are met.
- Billing for multiple vocational/habilitative services at the same time is prohibited.
- Prevocational services cannot be billed for on the same day at the same time as any of the following services:
 - Community Living Supports;
 - Professional Services (except those direct contacts needed to develop a behavioral management plan); or
 - Respite Care Services - Out of Home.

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Day Habilitation Services

Day Habilitation services are provided to recipients with the goal of developing activities and/or skills acquisition to increase independence, autonomy, and assist in the development of community integration.

The primary focus of Day Habilitation services is acquisition of new skills or maintenance of existing skills based on individualized preferences and goals. Day Habilitation services are to focus on providing supports and teaching opportunities which will enable recipients to attain their maximum skill capacity and shall be coordinated with any physical, occupational, or speech therapies listed in the recipient's POC. In addition, Day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. Progress for skill acquisition/maintenance activities is to be routinely reviewed and evaluated with revisions made as necessary to promote continued skill acquisition. The recipient does not receive payment for the activities in which they are engaged.

Day Habilitation services must be directed by a service plan that has been developed by the provider to address the recipient's POC goals, and to provide assistance and/or training in the performance of tasks related to acquiring, maintaining, or improving skills including but not limited to the following:

- Personal grooming,
- Housekeeping,
- Laundry,
- Cooking,
- Shopping, and
- Money management.

Some examples of Day Habilitation services include, but are not limited to, the following:

- Assisting and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs, and any medical task which can be delegated. Personal care assistance may not comprise the entirety of this service.

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- Receiving personal care skills training at a facility to improve his/her adaptive skills.
- Participating in a community inclusion activity designed to enhance the recipient's social skills.
- Training in basic nutrition and cooking skills at a community center.
- Participating, for an older recipient, with a group of senior citizens in a structured activity. This may include activities such as community-based activities sponsored by the local Council on Aging.
- Receiving aerobic aquatics in an inclusive setting to maintain the recipient's range of motion.
- Learning how to use a vacuum cleaner.
- Learning how to make choices and ordering from a fast food restaurant.
- Learning how to observe basic personal safety skills.
- Doing non-paid work in the community alongside peers without disabilities to improve social skills and establish connections.
- Receiving, as appropriate with his/her family, information and counseling on benefits planning and assistance in the process.

Transportation

Transportation for Day Habilitation services has a specific procedure code for billing purposes. Whenever possible, natural supports are encouraged to provide transportation. Under no circumstances can a provider charge a recipient, his/her responsible representative(s), family members or other support team members a separate transportation fee. However, the provider is responsible for all transportation from the agency to all sites related to Day Habilitation services. Transportation is payable only when a Day Habilitation service is provided on the same day. Transportation providers must carry \$1,000,000 liability insurance on the vehicles used in transporting the recipients.

Service Units and Limitations

Services are to be furnished on a regularly scheduled basis, for one or more days per week based on a 2.5 hour unit of service.

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- Must have 2.5 hours up to 5 hours for the first unit; 5 hours and over for the second unit spent at the service site per recipient per day.
- A total of two units may be billed if the recipient spends a minimum of 5 hours spent at the service site.
- Any time less than 2.5 hours of service is not billable or payable.
- No rounding up of hours, such as 4.5 equals 5 is allowed.
- The recipient may receive more than one type of vocational/habilitation service per day provided that the billing criteria and the requirements for the minimum time spent on site are met.
- Billing for multiple vocational/habilitative services at the same time is prohibited.
- Day Habilitation services cannot be billed for on the same day at the same time as any of the following services:
 - Community Living Supports;
 - Professional Services (except those direct contacts needed to develop a behavioral management plan); or
 - Respite Care Services - Out of Home.

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SECTION 38.2: SELF-DIRECTION OPTION**PAGE(S) 1**

SELF-DIRECTION OPTION

Self-direction is a service delivery option which allows recipients to become the employer of the direct service workers they choose to hire to provide their supports. As the employer, the recipient or his/her authorized representative are responsible for recruiting, training, supervising, and managing the direct service workers. This option gives the recipients the most control over their supports and services.

A required component of this option is the use of a contracted fiscal/employer agent, who will perform the recipient's employer-related payroll functions. Recipients must utilize support coordination services for the development of the Plan of Care (POC), budget planning, ongoing evaluation of supports and services, and for organizing the unique resources the recipient needs.

In the Residential Options Waiver (ROW), a recipient may choose to self-direct all or part of his/her Community Living Supports. Recipients can choose to receive other services for which he/she is eligible from a provider agency.

Recipients participating in this option must:

- Be a ROW recipient;
- Be able to participate in this self-direction service option without a lapse or decline in quality of care or an increased risk to his/her health and welfare;
- Complete the mandatory training including rights and responsibilities of managing his/her own services and supports offered by the support coordinator; and
- Understand the right, risks, and responsibilities of managing his/her own care, managing and using an individual budget; or if unable to make decisions independently, have a willing decision maker (authorized representative who is listed on the recipient's POC) who understands the rights, risks, and responsibilities of managing the care and supports of the recipient within his/her individualized budget.

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SECTION 38.3: RECIPIENT REQUIREMENTS**PAGE(S) 5**

RECIPIENT REQUIREMENTS

To qualify for the Residential Options Waiver (ROW), an individual must be offered a waiver opportunity and meet all of the following eligibility criteria:

- A developmental disability as defined in the Developmental Disability Law (See Appendix A),
- Financial and non-financial Medicaid eligibility criteria for home and community-based waiver services:
 - Income equals 300% of the Supplemental Security Income (SSI) Federal Benefit Rate (FBR).
 - SSI disability criteria,
 - Intermediate care facility for people with developmental disability (ICF/DD) level of care criteria, and
 - All other non-financial requirements such as:
 - Citizenship (U.S. citizen or qualified alien),
 - Resident of Louisiana,
 - Social Security number, and
- A Plan of Care (POC) that is sufficient to assure the health and welfare of the waiver applicant in order to be approved for waiver participation or continued participation. Health and welfare requirements of the person must be assured within the cost limit of the ROW (100% of the cost of care for the highest acuity level for persons in private ICFs/DD).
- Criteria for one of the following target groups:
 - Meets the ICF/DD level of care and is being served in the Office for Citizens with Developmental Disabilities (OCDD) Host Home contracts;
 - Meet the ICF/DD level of care and needs Home and Community-Based Services (HCBS) due to a health and/or safety crises situation (crisis diversion);
 - Is an adult in a nursing facility (NF) who is appropriate for transition to HCBS residential services, meets the level of care (LOC) to qualify for ROW eligibility and who is on the Request For Services Registry (RFSR);

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SECTION 38.3: RECIPIENT REQUIREMENTS**PAGE(S) 5**

- Is a child (birth through age 18) in a NF requiring high-need rates who is appropriate for transition to HCBS residential services and who meets the LOC to qualify for ROW eligibility and must participate in the Money Follows the Person (MFP) Rebalancing Demonstration;
- Is a resident in an ICF/DD who wishes to transition to HCBS residential services through a voluntary conversion opportunity and who has a choice of participating in the MFP Rebalancing Demonstration;
- Is a resident in an ICF/DD who is on the RFSR who wishes to transition to HCBS residential services and are eligible for the ROW: or
- Is a resident in a Supports and Services Center who wishes to transition to HCBS residential services.

Persons residing in ICFs/DD who wish to transition to HCBS residential services, who are eligible for the ROW and who are on the RFSR have a choice of participating in the MFP Rebalancing Demonstration. All persons who participate must meet criteria for participation established by OCDD protocol and must meet demonstration operational parameters (e.g. available funding) established by the demonstration award.

To remain eligible for waiver services, a recipient must receive a waiver service every thirty days.

There is no age restriction for individuals to access the ROW.

Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Requests for waiver services are made through the applicant's local OCDD regional office or Human Services Authority or District. Only requests from the applicant or his/her authorized representative will be accepted.

Once it has been determined by the OCDD regional office or Human Services Authority or District that the applicant meets the definition of a developmental disability as defined by the Louisiana Developmental Disability Law (See Appendix A), the applicant's name will be placed on the RFSR in request date order and the applicant/family will be sent a letter stating the individual's name has been secured on the RFSR along with the original request date. Entry into the waiver will be offered to applicants from the RFSR by date/time order of the earliest request for services. Applicants or their family may verify the date of request on the RFSR by calling the applicant's local OCDD regional office or Human Services Authority or District.

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SECTION 38.3: RECIPIENT REQUIREMENTS**PAGE(S) 5**

Level of Care

The ROW is an alternative to institutional care. All waiver applicants must meet the definition of developmental disability (DD) as defined in Appendix A. The OCDD Regional Supports and Services Office or Human Services Authority or District will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD).

The “Request for Medical Eligibility Determination,” BHSF Form 90-L is the instrument used to determine if an applicant meets the level of care of an ICF/DD. The Form 90-L is submitted by the Medicaid data contractor at the time the initial waiver offer is sent to the applicant/family. The Form 90-L must be:

- Completed 90 days or less before the date the ROW service is approved to begin and annually thereafter,
- Completed, signed and dated by the applicant’s Louisiana licensed primary care physician, and
- Submitted with the initial or annual POC.

The applicant/family is responsible for obtaining the completed Form 90-L from the applicant’s primary care physician within the following timeframes:

- Prior to linkage to a support coordination agency for an initial offer.
- No more than 90 days before the annual POC start date.

The support coordinator is responsible for collecting the material necessary to make this determination, and convening the person-centered planning team to formulate the POC, which documents all services to be arranged, including both natural supports and those reimbursed under ROW.

Documentation of level of care and the POC is submitted to the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District for a decision to determine if the applicant meets the criteria and level of care requirements for admission to an ICF/DD. The OCDD staff assesses the overall support needs of the applicant, including health and welfare, and determines if they will be met by the services and supports designed.

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SECTION 38.3: RECIPIENT REQUIREMENTS**PAGE(S) 5**

Denial or Discharge Criteria

Recipients will be denied admission to or discharged from the waiver if one of the following criteria is met:

- The individual does not meet the criteria for Medicaid financial eligibility.
- The individual does not meet the criteria for an ICF/DD level of care as determined by the OCDD Regional Waiver Supports and Services Office or Human Services Authority or District.
- The recipient is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile authorities.
- The recipient resides in another state or has a change of residence to another state.
- The recipient is admitted to an ICF/DD or nursing facility without the intent to return to waiver services. The waiver recipient may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The recipient will be discharged from the waiver on the 91st day if still in the facility. Payment for waiver services will not be authorized when the recipient is in a facility.
- The health, safety and welfare of the individual cannot be assured through the provision of reasonable amounts of waiver services in the community, i.e., the recipient presents a danger to himself/herself or others.
- The individual fails to cooperate in the eligibility determination process, the initial or annual implementation of the POC, or fulfilling his/her responsibilities as a ROW recipient.
- Continuity of services is interrupted as a result of the recipient not receiving and/or refusing waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

NOTE: Continuity of services will not apply to interruptions due to hospitalization, institutionalization or if a family member has agreed to provide all paid documented supports (not to exceed 90 days) that are listed in the POC during a non-routine lapse of time in waiver services. There will not be an authorization for payment of waiver services during this time.

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SECTION 38.3: RECIPIENT REQUIREMENTS

In the event of a Force Majeure, support coordination agencies, direct service providers, and recipients whenever possible, will be informed in writing, and/or by phone and/or via the Louisiana State Medicaid website of interim guidelines and timelines for retention of waiver slots and/or temporary suspension of continuity of services.

The direct service provider is required to notify the support coordination agency within 24 hours if they have knowledge that the recipient has met any of the above stated discharge criteria.

RIGHTS AND RESPONSIBILITIES

Recipients of Residential Options Waiver (ROW) services are entitled to the specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs and those contained in the Louisiana Developmental Disability Law of 2005 (Louisiana R.S. 28:452.1).

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 regarding recipient rights.

Freedom of Choice of Program

Applicants/recipients, who qualify for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) level of care, have the freedom to select institutional or community-based services. Applicants/recipients have the responsibility to participate in the evaluation process. This includes providing the medical and other pertinent information or assisting in obtaining it for use in the person-centered planning process and certification for services.

Notification of Changes

Support coordinators and service providers may not approve or deny eligibility for the waiver or approve services in the waiver program.

The Department of Health and Hospitals (DHH) - Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the ROW program. In order to maintain eligibility, recipients have the responsibility to inform BHSF of changes in their income, address, and living situation.

The DHH - Office for Citizens with Developmental Disabilities (OCDD) is responsible for approving level of care and medical certification per the Plan of Care (POC). In order to maintain this certification, recipients have the responsibility to inform OCDD through their support coordinator of any significant changes, which will affect their service needs.

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SECTION 38.4: RIGHTS AND RESPONSIBILITIES**PAGE(S) 3****Participation in Care**

Support coordinators and service providers shall allow recipients/authorized representatives to participate in all person-centered planning meetings and any other meeting concerning their services and supports. 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.

In order for providers to offer the level of service necessary to ensure the recipient's health, welfare, and support, the recipient must report any change in his/her service needs to the support coordinator and service provider(s).

The support coordinator must request changes in the amount of services at least seven days before taking effect, except in emergencies. Service providers may not initiate requests for change of service or modify the POC without the participation and consent of the recipient.

Freedom of Choice of Support Coordination and Service Providers

Support coordinators should be aware that at the time of admission to the waiver and every six months thereafter, recipients have the opportunity to change providers, if one is available. Recipients may request a change by contacting the OCDD Regional Waiver Office or Human Services Authority or District.

Support coordinators will provide recipients with their choice of direct service providers and help arrange for the services included in the POC. Recipients have the opportunity to choose service providers initially and every six months thereafter unless a change is requested for good cause.

Voluntary Participation

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

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SECTION 38.4: RIGHTS AND RESPONSIBILITIES**PAGE(S) 3****Compliance with Civil Rights**

Providers shall operate in accordance with Titles 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 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 providers by not requesting services, which in any way violate state or federal laws.

Quality of Care

Providers must be competent, trained, and qualified to provide services to recipients as outlined in the POC. In cases where services are not delivered according to the POC, or there is abuse or neglect on the part of the provider, the recipient shall follow the complaint reporting procedure and cooperate in the investigation and resolution of the complaint. Recipients may not request providers to perform tasks that are illegal or inappropriate and may not violate the rights of providers.

Grievances/Fair Hearings

Each support coordination/direct service provider shall have grievance procedures through which recipients may grieve the supports or services they receive. The support coordinator shall advise recipients of this right and of their rights to appeal any denial or exclusion from the program or failure to recognize a recipient's choice of a service and of his/her right to a fair hearing through the Medicaid program. In the event of a fair hearing, a representative of the service provider and support coordination agency shall appear and participate in the proceedings.

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

Rights and Responsibilities Form

A copy of the form with a complete list of the recipient's rights and responsibilities can be found on the website. (Refer to Appendix D). The support coordinator must review these rights and responsibilities with the recipient and his/her authorized representative as part of the initial intake process into waiver services.

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SECTION 38.5: SERVICE ACCESS AND AUTHORIZATION PAGE(S) 9

SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Residential Options Waiver (ROW) opportunity or an existing opportunity is vacated, the next individual on the Request for Services Registry (RFSR) will receive a written notice indicating that a waiver opportunity is available. That individual will be evaluated for a possible ROW assignment.

The applicant will receive a waiver offer packet that includes a Support Coordination Agency Freedom of Choice (FOC) form. The support coordinator is a resource to assist individuals in the coordination of needed supports and services. The applicant must complete and return the packet to be linked to a support coordination agency.

Prior to linkage to a support coordination agency, the applicant must have provided the Medicaid data contractor with a current 90-L form that has been completed, signed and dated by his/her Louisiana licensed primary care physician. Once linked, the support coordinator will assist the applicant in gathering the documents which may be needed for both the financial eligibility and medical certification process for level of care determination. The support coordinator informs the individual of the freedom of choice of enrolled waiver providers, the availability of services as well as the assistance provided through the support coordination service.

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 applicant's assessed needs,
- The types and number of services (including waiver and all other services) necessary to maintain the applicant safely in the community,
- The individual cost of each service (including waiver and all other services), and
- The average cost of services per day covered by the POC.

Provider Selection

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

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The support coordinator is responsible for:

- Notifying the provider that the recipient has selected their agency to provide the necessary service,
- Requesting the provider sign and return the:
 - Provider agreement form,
 - Emergency plan, and
 - Individualized Staffing Back-up Plan.
- Forwarding the POC packet to the Office for Citizens with Developmental Disabilities (OCDD) Regional Waiver Office or Human Services Authority or District for review and approval.

NOTE: The authorization to provide service is contingent upon approval by the OCDD Regional Waiver Office or Human Services Authority or District.

Prior Authorization

All services in the ROW program 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. Prior authorizations are issued in quarterly intervals directly to the provider, with the last quarterly authorization ending on the POC end date.

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 prior authorization are not eligible for reimbursement.

The service provider is responsible for the following activities:

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

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- Verifying that the direct service worker's timesheet is completed correctly and that services were delivered according to the recipient's approved POC prior to billing for the service.
- Verifying that services were documented as evidenced by timesheets and progress notes and are within the approved service limits as identified in the recipient's POC prior to billing for the service.
- Completing data entry into the direct service provider data system, Louisiana Services Tracking (LAST) system.
- 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 DHH fiscal intermediary with each payment.
- Checking billing records to ensure that the appropriate payment was received. (Note: Service providers have one-year timely filing billing requirement under Medicaid regulations.)

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

NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances.

Post Authorization

To receive post authorization, a service provider must enter the required information into the billing system maintained by the Medicaid data contractor. The Medicaid data contractor checks the information entered into the billing system by the service provider against the prior authorized unit of service. Once post authorization is granted, the service provider may bill the DHH 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.

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One - Time Transitional Expenses

The support coordinator must develop a plan to include the transition expenses for individuals who are moving from an Intermediate Care Facility for people with Developmental Disabilities (ICF/DD) into their own residence in the community. No funds will be disbursed without prior authorization of expenditures. The following procedure must be followed to access these funds:

- The support coordinator must complete the “Transitional Expenses Planning and Approval (TEPA) Request Form,” with input from the recipient and his/her circle of support, to document the need for transitional expenses, identify the designated purchaser, and estimate the cost of the items or services that are needed. The recipient may choose to be the designated purchaser or may select his/her authorized representative, support coordinator, or provider to act as the designated purchaser. (See Appendix D for a copy of this form)
- The support coordinator must request pre-approval from the OCDD Regional Waiver Office or Human Services Authority or District by submitting the TEPA request form and the POC packet, including the POC budget sheet identifying the estimated TEPA cost, procedure code, provider and provider number, at least 10 working days prior to the recipient’s actual move date.
- The OCDD Regional Waiver Office or Human Services Authority or District sends the completed pre-142 approval letter and pre-approved TEPA request form to the support coordinator and OCDD State Office Fiscal Section. A copy of the pre-142 approval letter will also be sent to the Medicaid parish office. The purchasing process cannot begin until the pre-142 approval letter is issued to the support coordinator.
- The support coordinator assists the designated purchaser with obtaining the items on the pre-approved TEPA request form.
- After purchases are made, the support coordinator is responsible for:
 - Obtaining the original receipts from the designated purchaser,
 - Identifying the pre-approved items to be reimbursed,
 - Notating the actual cost of the pre-approved items on the TEPA request form,
 - Summarizing all items purchased by the designated purchaser on the “TEPA Invoice” form,
 - Completing the “Request for Taxpayer Identification Number and Certification” (W-9 form) if the designated purchaser is not established as a state vendor, and

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- Informing the designated purchaser of the timeframes and procedures to be followed in order to obtain reimbursement.
- The support coordinator must submit the pre-approved TEPA request form, original receipts, W-9 form (if applicable), and the TEPA Invoice form to the OCDD Regional Waiver Office or Human Services Authority or District at least 10 working days following the pre-certification home visit.
- The OCDD Regional Waiver Office or Human Services Authority or District reviews the purchased items with the recipient/authorized representative at the pre-certification home visit for approval.
- The OCDD Regional Waiver Office or Human Services Authority or District mails the 18-W form, original receipts, pre-approved TEPA request form, and TEPA Invoice form to the OCDD State Office Fiscal Section upon receipt. Payment will not be authorized until the OCDD Regional Waiver Office or Human Services Authority or District gives final POC approval upon receipt of the 18-W form.
- The OCDD State Office Fiscal Section establishes a transition expense record for the recipient and utilizes the pre-approved TEPA request form to ensure that only the item/services listed are reimbursed to the designated purchaser.
- The support coordinator must submit to the OCDD Regional Waiver Office or Human Services Authority or District a revised POC budget sheet if there are any cost differences between the approved estimated TEPA cost and the actual TEPA cost.
- The OCDD State Office Fiscal Section sends the “OCDD Verification of Actual TEPA Costs” form to the OCDD Regional Waiver Office or Human Services Authority or District for service authorization.
- The OCDD Regional Waiver Office or Human Services Authority or District gives final approval on the “OCDD Verification of Actual TEPA Costs” form and faxes it to the Medicaid data contractor along with the approved TEPA request form and accompanying POC budget sheets. A copy of the “OCDD Verification of Actual TEPA Costs” form is faxed back to the OCDD State Office Fiscal Section for documentation in the OCDD payment record.
- Service authorization is issued to the OCDD State Office Fiscal Section for the actual cost of items as identified on the approved TEPA request form. Any new items not on the original approved TEPA Request Form will not be reimbursed.

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- The OCDD State Office forwards the reimbursements to the designated purchaser upon payment from Medicaid.

All billing must be completed by the POC end date in order for the reimbursement to be paid. OCDD State Office Fiscal Section maintains documentation for accounting and monitoring purposes of each recipient's TEPA request including original receipts and record of payments to the designated purchaser

Additional requests for One Time Transitional Expenses must be requested by the recipient and submitted by the support coordinator on a new TEPA request form to the OCDD Regional Waiver Office or Human Services Authority or District following the above procedure. Requests may be submitted up to 30 calendar days after the stamped receipt date of the 18-W in the OCDD Regional Waiver Office or Human Services Authority or District.

Changes in Service Needs

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

Changing Direct Service Providers

Recipients may change direct service providers once every service authorization quarter (three months) with the effective date being the beginning of the following quarter. Direct service providers may be changed for good cause at any time as approved by the OCDD Regional Waiver Office or Human Services Authority or District.

Good cause is defined as:

- A recipient moving to another region in the state where the current direct service provider does not provide services,
- The recipient and the direct service provider have unresolved difficulties and mutually agree to a transfer,
- The recipient would like to share supports with another recipient who has a different provider agency, regardless of the recipients' relationship,
- The recipient's health, safety or welfare have been compromised, or
- The direct service provider has not rendered services in a manner satisfactory to the recipient or his/her authorized representative.

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Recipients and/or their authorized representative must contact their support coordinator to change direct service providers.

The support coordinator will assist in facilitating a support team meeting to address the recipient's reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider should have the opportunity to submit a corrective action plan with specific timelines, not to exceed 30 days, to attempt to meet the needs of the recipient.

If the recipient/authorized representative refuses a team meeting, the support coordinator and OCDD Regional Waiver Office or Human Services Authority or District determine that a meeting is not possible or appropriate, or the corrective action plan and timelines are not met, the support coordinator will:

- Provide the recipient/ authorized representative with a current FOC list of service providers in his/her region.
- Assist the recipient/authorized representative in completing the FOC list and release of information form,
- Ensure the current provider agency is notified immediately upon knowledge and prior to the transfer, and
- Obtain the case record from the releasing provider which must include:
 - Progress notes from the last two months, or if the recipient has received services from the provider for less than two months, all progress notes from date of admission,
 - Written documentation of services provided, including monthly and quarterly progress summaries,
 - Current Individualized Service Plan (ISP),
 - Records tracking recipient's progress towards ISP goals and objectives, including standardized vocational assessments and/or notes regarding community or facility-based work assessments, if applicable,
 - Records of job assessment, discovery, and development activities which occurred, and a stated goal and objective in the most current ISP for the recipient to obtain competitive work in the community, if stated,

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- Copies of current and past behavior management plans, if applicable,
- Documentation of the amount of authorized services remaining in the POC including applicable time sheets, and
- Documentation of exit interview.

The support coordinator will 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,
- Records from the previous service provider, and
- All other waiver documents necessary for the new service provider to begin providing service.

Transfers must be made seven days prior to the end of the service authorization quarter in order to coordinate services and billing, unless the OCDD regional waiver office waives this requirement in writing due to good cause.

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

Prior Authorization for New Service Providers

A new PA number will be issued to the new provider with an effective starting date of the first day of the new quarter or the first day of the first full calendar month following a good cause change. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider.

Neither OCDD nor its agent will backdate the new PA period to the first day of the first full calendar month in which the FOC and transfer of records are completed. If the new provider receives the records and admits a recipient in the middle of a month, the new provider cannot bill for services until the first day of the next month. New providers who provide services prior to the begin date of the new PA period will not be reimbursed.

Exceptions to the existing service provider end date and the new service provider begin date may be approved by the OCDD Regional Waiver Office or Human Services Authority or District when the reason for change is due to good cause as specified above.

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Changing Support Coordination Agencies

A recipient may change support coordination agencies after a six month period or at any time for good cause if the new agency has not met its maximum number of recipients. Good cause is defined as:

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

Participating support coordination agencies should refer to the Medicaid Case Management Services manual chapter which provides a detailed description of their roles and responsibilities.

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SECTION 38.6: PROVIDER REQUIREMENTS**PAGE(S) 22**

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 for licensure as established by state laws and rules promulgated by the Department of Health and Hospitals (DHH),
- Agree to abide by all rules and regulations established by the Centers for Medicare and Medicaid Services (CMS), DHH and other state agencies if applicable, and
- Comply with all the terms and conditions for Medicaid enrollment.

Providers must attend all mandated meetings and training sessions as directed by OCDD as a condition of enrollment and continued participation as a waiver provider. Attendance at a provider enrollment orientation is required prior to enrollment as a Medicaid provider. A Provider Enrollment Packet must be completed for each DHH administrative region in which the agency will provide 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.

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

Providers must have available computer equipment and software necessary to participate in prior authorization and data collection.

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

Brochures providing information on the agency's experience must include the agency's toll-free number along with the OCDD's toll-free information number. OCDD must approve all brochures prior to use.

Providers must develop a Quality Improvement and Self-Assessment Plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first Self-Assessment is due six months after approval of the Quality Improvement Plan and yearly thereafter. The Quality Improvement Plan must be submitted for approval within 60 days after the training is provided by DHH.

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Providers must be certified for a period of one year. Re-certification must be completed no less than 60 days prior to the expiration of the certification period.

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

Changes in the following areas are to be reported to the Bureau of Health Services Financing Health Standards Section, OCDD and the Fiscal Intermediary's Provider Enrollment Section in writing at least 10 days prior to any change:

- Ownership,
- Physical location,
- Mailing address,
- Telephone number, and
- Account information affecting electronic funds transfer (EFT).

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

Waiver services are to be provided only to persons who are waiver recipients, and strictly in accordance with the provisions of the approved Plan of Care (POC).

Providers may not refuse to serve any waiver recipient that chooses their agency unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. Such refusal to serve an individual must be put in writing by the provider, and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the OCDD Regional Waiver Office or the Human Service Authority or District. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver recipient referred to them by the enrolled direct service provider agency.

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SECTION 38.6: PROVIDER REQUIREMENTS

The recipient’s provider and support coordination agency must have a written working agreement that includes the following:

- Written notification of the time frames for POC planning meetings,
- Timely notification of meeting dates and times to allow for provider participation,
- Information on how the agency is notified when there is a POC or service delivery change, and
- Assurance that the appropriate provider representative is present at planning meetings as invited by the recipient.

The ROW services outlined below may be provided by the provider or by an agreement with other contracted agents. The actual provider of the service, whether it is the provider or a subcontracted agent, must meet the following licensure or other qualifications:

Waiver Service	Requirements	Service Provided by
Support Coordination	<p style="text-align: center;">Case Management License</p> <p>Providers of support coordination for the ROW program must have a signed performance agreement with OCDD to provide services to waiver recipients.</p> <p>Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined in the Case Management Services manual chapter, state rule, and ROW Provider Manual.</p>	<p>Provider Type 45: Case Management-Contract</p> <p>Specialty 81: Case Management</p> <p>Subspecialty: 4W</p>
Community Living Supports	<p style="text-align: center;">Personal Care Attendant Module</p> <p style="text-align: center;">Self-Direction Option Available</p>	<p>Provider Type 82: Personal Care Attendant</p> <p>Specialty 82: Personal Care Attendant</p> <p>Subspecialty: 4W</p>
Companion Care	<p style="text-align: center;">Personal Care Attendant Module</p>	<p>Provider Type 82: Personal Care Attendant</p> <p>Specialty 82: Personal Care Attendant</p> <p>Subspecialty: 4W</p>

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<p>Shared Living</p>	<p>Supervised Independent Living Module Supervised Independent Lining Conversion Module</p> <p>Shared Living Providers must also have OCDD approval which includes:</p> <ul style="list-style-type: none"> • Conversion Option: <ul style="list-style-type: none"> • Current ICF/DD provider in good standing and licensed to operate by DHH-Health Standards Section (Conversion Module); • Apply for and meet ROW provider qualifications for the Shared Living Conversion; and • OCDD regional office will document that the Shared Living option was explained to, understood by and agreed upon by all individuals who will be affected when the ICF/DD is closed and the license is surrendered. • New Option: <ul style="list-style-type: none"> • If any ICF/DD license is held or was previously held, the licensee must be or have been a provider in good standing; and • Apply for and meet ROW provider qualifications for the Shared Living. 	<p>Provider Type 11: Shared Living</p> <p>Specialty 4A: DD</p> <p>Subspecialties: <u>Conversion Option:</u> 4J-Provider Owned/Leased Residence 4H- Participant Owned/Leased Residence</p> <p><u>New Option:</u> 4G-Provider Owned/Leased Residence 4L- Participant Owned/Leased Residence</p>
<p>One Time Transitional Expenses</p>		<p>OCDD</p>
<p>Host Home</p>	<p>Substitute Family Care Module when providing services to adults Class “A” Child Placing License when provider services to children</p> <p>Providers must:</p> <ul style="list-style-type: none"> • Have experience in delivering therapeutic services to persons with developmental disabilities; and • Have staff who have experience working with persons with developmental disabilities 	<p>Provider Type 84: Substitute Family Care</p> <p>Specialty 84: Substitute Family Care</p> <p>Subspecialty: 4W</p>
<p>Center Based Respite</p>	<p>Respite Module for a facility</p>	<p>Provider Type 83: Waiver-Respite Care</p> <p>Specialty 83: Respite Care</p>

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<p>Environmental Accessibility Adaptations</p>	<p style="text-align: center;">Home Adaptations: Providers must be registered through the Louisiana State Licensing Board for Contractors as a General Contractor, Home Improvement Contractor, or Residential Building Contractor.</p> <p>Environmental Modification providers must meet the following requirements:</p> <ul style="list-style-type: none"> • Must be enrolled as a Medicaid Environmental Modifications Provider • Must comply with all applicable Local (City or Parish) Occupational License(s). • All services shall be provided in accordance with applicable State or local requirements. • Must meet any state or local requirements for licensure or certification for the work performed, as well as the person performing the service (i.e., building contractors, plumbers, electricians, or engineers); • Must meet such standards for modifications to the home when state and local building or housing code standards are applicable; • If currently enrolled in Louisiana Medicaid as a DME provider, documentation from the manufacturing company (on their company letterhead) that confirms this DME provider is an authorized distributor of a specific product that attaches to a building. This letter must specify the product and must state that this DME provider has been trained on its installation. 	<p>Provider Type 15: Environmental Modifications</p> <p>Specialty 80: Environmental Modifications</p>
	<p style="text-align: center;">Vehicle Adaptations Providers must be licensed by the Louisiana Motor Vehicle Commission as a Specialty Vehicle Dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.</p> <p>Vehicle Modification providers must meet the following requirements:</p> <ul style="list-style-type: none"> • Must be enrolled as a Medicaid Environmental Modifications Provider • Must comply with all applicable Local (City or Parish) Occupational License(s). • All services shall be provided in accordance with applicable State or local requirements. 	

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<p>Assistive Technology/Specialized Medical Equipment and Supplies</p>	<p>Must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.</p> <p>If currently enrolled in Louisiana Medicaid as a DME provider, documentation from the manufacturing company (on their letterhead) that confirms this DME provider is an authorized distributor of a specific product that attaches to a building. This letter must specify the product and must state that this DME provider has been trained on its installation.</p>	<p>Provider Type 17: Assistive Devices</p> <p>Specialty 91: Assistive Devices</p>
<p>Personal Emergency Response Systems</p>	<p>Must meet all applicable vendor requirements, federal, state, parish and local laws for installation.</p>	<p>Provider Type 16: Personal Emergency Response Systems</p> <p>Specialty 90: Personal Emergency Response Systems (Waiver)</p>
<p>Transportation-Community Access</p>	<p>Must maintain the state minimum automobile liability insurance coverage, have a current state inspection sticker, and have a current valid driver's license</p>	<p>Provider Type 42: Friends and Family</p> <p>Specialty: 4W</p> <p>Subspecialty: 4W</p>
<p>Professional Services:</p>	<p>Must possess a current valid Louisiana license to practice in the field of expertise:</p> <p style="text-align: center;">Registered Dietician Speech Therapist Occupational Therapist Physical Therapist Social Worker Psychologist</p> <p>Professionals are able to enroll individually and/or be linked to an agency. Professional Providers must meet the following requirements:</p> <p>Professionals must have one year experience delivering services to persons with developmental disabilities. OCDD requires verification that every professional meets the one year experience requirement for delivering services to persons with developmental disabilities based on the following criteria:</p>	<p>Individual Enrollment</p> <p>Provider Type 41: Registered Dietician</p> <p>Specialty 4R: Registered Dietician</p> <p>Provider Type 39: Speech Therapist</p> <p>Specialty 71: Speech Therapy</p> <p>Provider Type 37: Occupational Therapist</p>

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	<ul style="list-style-type: none"> • Full-time employment gained in advanced and accredited training programs (i.e., masters or residency level training programs) which includes services for persons with developmental disabilities); • Paid, full-time professional experience in specialized service/treatment settings for persons with developmental disabilities (i.e., intermediate care facilities for persons with developmental disabilities); • Paid, full-time professional experience in multi-disciplinary programs for persons with developmental disabilities (i.e., mental health treatment programs for persons with dual diagnosis-mental illness and developmental disabilities); • Paid, full-time professional experience in specialized educational, vocational and therapeutic programs or settings for persons with developmental disabilities (i.e., school special education program); • Two years of part-time experience (minimum of 20 hours per week) may be substituted for one year of full-time experience; • Items that do not qualify for the required experience: <ul style="list-style-type: none"> • Volunteer professional experience; and • Experience gained in caring for a relative or friend with developmental disabilities. <p>If a professional chooses to link to an agency, the agency must be licensed by the Louisiana Department of Health and Hospitals as one of the following:</p> <ul style="list-style-type: none"> • Home Health Agency; • Free-Standing Rehab Clinic; • Supervised Independent Living Agency (Shared Living) • Substitute Family Care (Host Home-Adult); or • Class “A” Child Placing Agency (Host Home-Child) by the Department of Children and Family Services 	<p>Specialty 74: Occupational Therapy</p> <p>Provider Type 35: Physical Therapist</p> <p>Specialty 65: Indiv Physical Therapy</p> <p>Provider Type 73: Social Worker</p> <p>Specialty 73: Social Work</p> <p>Provider Type 31: Psychologist</p> <p>Specialty 62: Psychologist (Crossovers Only)</p> <p>Specialty 95: Psychologist (PBS Program Only)</p> <p>Specialty 96: Psychologist (PBS Program and Crossovers)</p> <p>For All Professionals: Subspecialty: 4W</p> <p>Individual Professionals can link to:</p> <p>Provider Type 11: Shared Living and/or</p> <p>Provider Type 84: Substitute Family Care</p>
<p>Nursing</p>	<p>Registered Nurse and Licensed Practical Nurse: must meet Louisiana licensing requirements</p> <p>Nurses are only able to provide services by linking to an agency. The agency must be licensed by the Louisiana Department of Health and Hospitals as one of the following:</p> <ul style="list-style-type: none"> • Home Health Agency; or • Shared Living (only Subspecialty-Conversion) 	<p>Must be linked to:</p> <p>Provider Type 11: Shared Living Agency (only w/Subspecialty 4H and/or 4J) or</p> <p>Provider Type 44: Home Health</p>

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	<p>Nurses must have one year experience delivering services to persons with developmental disabilities. OCDD requires verification that every professional meets the one year experience requirement for delivering services to persons with developmental disabilities based on the following criteria:</p> <ul style="list-style-type: none"> • Full-time experience gained in advanced and accredited training programs (i.e., masters or residency level training programs) which includes treatment services to persons with developmental disabilities); • Paid, full-time experience in specialized service/treatment services for persons with developmental disabilities (i.e., intermediate care facilities for persons with developmental disabilities); • Paid, full-time nursing experience in multi-disciplinary programs for persons with developmental disabilities (i.e., mental health treatment programs for persons with dual diagnosis-mental illness and developmental disabilities); or • Paid, full-time nursing experience in specialized education, vocational and therapeutic programs or settings for persons with developmental disabilities (i.e., school special education program) • <u>Note:</u> Two years of part-time experience (minimum of 20 hours per week) may be substituted for one year of full-time experience. • Activities not included toward the required experience include: <ul style="list-style-type: none"> • Volunteer nursing experience; and • Experience gained by caring for a relative or friend with developmental disabilities. 	<p>Agency</p> <p>Specialty 87: All Other</p> <p>Subspecialty: 4W</p> <hr/>
<p>Dental</p>	<p>Current valid Louisiana license to practice in the field of expertise/specialty</p>	<p>Provider 27: Dental-Individual or Group</p> <p>Specialty19: Orthodontist</p> <p>Specialty 66: Dentist, DDS, DMS</p> <p>Specialty 67: Oral Surgeon, Dental</p> <p>Specialty 68: Pedodontist</p>

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Supported Employment	Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or Adult Day Center Module	<p>Provider Type 98: Habilitative Supportive Employment</p> <p>Specialty 98: Supported Employment</p>
Prevocational Services	Adult Day Center Module	<p>Provider Type 13: Prevocational Habilitation</p> <p>Specialty 36: Prevocational Habilitation</p>
Day Habilitation	Adult Day Center Module	<p>Provider Type 14: Adult Day Habilitation</p> <p>Specialty 50: Day Habilitation</p>

When required by state law, the person performing the service, such as building contractors, plumbers, electricians, or engineers, must meet applicable requirements for professional licensure and modifications to the home and must meet all applicable building code standards.

A provider is able to enroll and select up to three sub-specialties per one provider number. For example, if a Shared Living Provider wishes to enroll and provide all four subspecialties, two separate provider numbers will need to be obtained.

Provider Responsibilities for All Providers

All providers of ROW services are responsible for the following:

- Ensuring an appropriate representative from the agency attends the POC planning meeting and is an active participant in the team meeting,

Note: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the recipient’s service delivery. This person may be a program manager, a direct service professional who works with or will work with the recipient, the executive director or designee.

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- Communicating and working with support coordinators and other support team members to achieve the recipient’s personal outcomes,
- Ensuring the recipient’s emergency contact information and list of medications are kept current,
- Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or time lines in the POC will not meet the recipient’s needs, but not later than 10 days prior to the expiration of any time lines in the service plan that cannot be met,
- Ensuring the provider agency support team member(s) sign and date any revisions to the service plan indicating agreement with the changes to the goals, objectives or time lines,
- Providing the support coordination agency or DHH representatives with requested written documentation including, but not limited to:
 - Completed, signed and dated service plan,
 - Service logs, progress notes, and progress summaries,
 - Direct service worker attendance and payroll records
 - Written grievances or complaints filed by recipients/family,
 - Critical or other incident reports involving the recipient, and
 - Entrance and exit interview documentation.
- Explaining to the recipient/family in his/her native language the recipient rights and responsibilities within the agency, and
- Assuring that recipients are free to make a choice of providers without undue influence.

Provider Responsibilities for All Residential Care Service Providers

Direct service provider agencies must have written policy and procedure manuals that include but are not limited to the following:

- Training policy that includes orientation and staff training requirements according to the Personal Care Attendant Module Standards, Supervised Independent Living Module Standards, Substitute Family Care Module Standards, Class A Child Placing Licensing Standards (as applicable to specific residential service being provided),

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- Direct care abilities, skills and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver recipients,
- Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing and staff coverage plan,
- Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal,
- Identification, notification and protection of recipient's rights both verbally and in writing in a language the recipient/family is able to understand,
- Written grievance procedures, and
- Information about abuse and neglect as defined by DHH regulations and state and federal laws.

Individualized Service Plan

The direct service provider must develop an individualized service plan to include all waiver services that the agency provides to the recipient based on the recipient's identified POC goals.

The individualized service plan must be person-centered, focus on the recipient's desired outcomes, and include the following elements:

- Specific goals matching the goals outlined in the recipient's approved POC,
- Measurable objectives and timelines to meet the specified goals,
- Strategies to meet the objectives,
- Identification of the direct service provider staff and any other support team members who will be involved in implementing the strategies, and
- The method that will be used to document and measure the implementation of specified goals and objectives.

The individualized service plan must be reviewed and updated as necessary to comply with the specified goals, objectives, and timelines stated in the recipient's approved POC.

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Back-up Planning

Direct service providers are responsible for providing all necessary staff to fulfill the health and welfare needs of the recipient when paid supports are scheduled to be provided. This includes times when the scheduled direct service worker is absent or unavailable or unable to work for any reason.

All direct service providers are required to develop a functional individualized back-up plan for each recipient that includes detailed strategies and person-specific information that addresses the specialized care and supports needed by the recipient. Direct service providers are required to have policies in place which outline the protocols the agency has established to assure that back-up direct service workers are readily available, lines of communication and chain of command procedures have been established, and procedures for dissemination of the back-up plan information to recipients, their authorized representatives and support coordinators. Protocols must also describe how and when the direct support staff will be trained in the care needed by the recipient. This training must occur prior to any direct support staff being solely responsible for a recipient.

Back-up plans must be updated at least annually to assure that the information is kept current and applicable to the recipient's needs. The back-up plan must be submitted to the recipient's support coordinator in a timely manner to be included as a component of the recipient's initial and annual POC.

Direct service providers may not use the recipient's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements. The recipient's family members and others identified in the recipient's circle of support may elect to provide backup, but this does not exempt the provider from the requirement of providing the necessary staff for backup purposes.

Emergency Evacuation Planning

Emergency evacuation plans must be developed in addition to the recipient's individualized back-up plan. Providers must have an emergency evacuation plan that specifies in detail how the direct service provider will respond to potential emergency situations such as fires, hurricanes, tropical storms, hazardous material release, flash flooding, ice storms, and terrorist attacks.

The emergency evacuation plan must be person-specific and include at a minimum the following components:

- Individualized risk assessment of potential health emergencies,

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- A detailed plan to address the recipient’s individualized evacuation needs, including a review of the recipient’s individualized back-up plan, during geographical and natural disaster emergencies and all other potential emergency conditions,
- Policies and procedures outlining the agency’s implementation of emergency evacuation plans and the coordination of these plans with the local Office of Emergency Preparedness and Homeland Security,
- Establishment of effective lines of communication and chain of command procedures,
- Establishment of procedures for the dissemination of the emergency evacuation plan to recipients and support coordinators, and
- Protocols outlining how and when direct service workers and recipients will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

Training for direct service workers must occur prior to the worker being solely responsible for the support of the recipient.

The recipient must be provided with regular, planned opportunities to practice the emergency evacuation response plan.

OCDD, support coordination agencies, and direct service provider agencies are responsible for following the established emergency protocol before, during, and after hurricanes as outlined in the “Emergency Protocol for Tracking Location Before, During, and After Hurricanes” document (Refer to Appendix D for website information).

Host Home Provider Responsibilities

The Host Home provider is responsible for screening, training, overseeing and providing technical assistance to Host Home families in accordance with OCDD requirements including the coordination of medical, behavioral, and other professional services geared to persons with developmental disabilities. Host Home Providers must provide on-going assistance to Host Home Families so that all HCBS waiver health and safety assurances, monitoring and critical incident reporting requirements are met. The Host Home provider and the Host Home family are required to participate in the POC process and follow the POC as indicated.

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Host Home Providers are responsible for:

- Assisting in the selection of Host Home Families (determining suitable matches between Host Home Families and Host Home recipients).
- Inspecting the home setting, completing reference checks on each person in the home (criminal record and background checks), conducting a home study, verifying Host Home Family has a stable income sufficient to meet routine expenses independent of ROW service payments, and making a certification determination of prospective Host Home Families.
- Developing contracts with Host Home Families.
- Participating in the development of the recipient's POC.
- Providing and/or arranging routine and specialized training specific to the needs of the recipient.
- Providing ongoing follow-up and oversight of Host Home Families to ensure the POC is being followed (including the documentation and maintenance of data and records), that the services being provided meet quality standards, that there is continuity of services, and that the home environment continues to be a safe and suitable environment.
- Providing emergency services as needed.
- Providing 24-hour oversight and supervision of Host Home services including approved alternative supports, and supervision as identified in the approved POC.
- Providing Host Home Family relief supports (scheduled and unscheduled relief) during absences of the Host Home Family with the following guidelines:
 - Limited to 360 hours (15 days) per POC year as indicated in the POC;
 - Relief staff for scheduled and unscheduled absences are included in the Host Home Provider's rate;
 - Relief staff for scheduled and unscheduled absences may be provided either in the Host Home Family setting or at a location of the recipient's choosing, but must be indicated in the POC;
 - The recipient (or if the recipient is a minor, the recipient's legal representative) may agree to have the recipient reside with another Host Home Family; and
 - Regardless of where the Host Home services are provided, the Host Home Provider is responsible for oversight, supervision and back-up of the Host Home service.
- Assuring that only persons approved in accordance with licensing regulations are allowed to provide services to or reside in the same residence as the recipient.

Host Home Families are responsible for:

- Participating with the Host Home Provider during the selection of Host Home families (determination of families as a suitable match for Host Home recipients);

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- Being available during inspections of the home setting, participating in a home study, and complying with all activities conducted by the Host Home Provider in the determination process;
- Participating in the Host Home Provider's contract development for the Host Home family;
- Participating in routine and specialized training specific to the needs of the recipient;
- Participating in the development of the recipient's POC;
- Following the recipient's POC and providing any specialized supports as specified in the POC;
- Providing assistance to ensure the recipient has access to community services/activities and in the development of community recreational and social interests;
- Providing assistance to the recipient in keeping medical appointments, therapy appointments, and other appointments necessary for the health and well-being of the recipient;
- Providing or arranging appropriate transportation to school, work, medical appointments, therapy appointments, and other appointments/activities necessary for the health and well-being of the recipient;
- If indicated in the POC, the Host Home Family will support the recipient in maintaining contact with his/her biological family and/or natural supports;
- Providing unpaid supports when the recipient is either working or interested in working;
- Maintaining adequate records to substantiate service delivery and producing such records upon request;
- Maintaining data to assist in the evaluation of the recipient's personal goals as identified in the POC and producing such records upon request; and
- Immediately reporting to the Host Home Provider any major issues or concerns related to the recipient's safety and well-being.

Host Home Services (Provided to Children)

Host Home Families who provide serves to children are required to provide daily supports and supervision on a 24-hour basis:

- To meet the on-going support needs of the recipient; and
- To handle emergencies as any family would do for their minor child as required based on age, capabilities, health conditions and special needs.

Providers serving children or adults in the Host Home setting must meet the following requirements:

- Have experience in delivering therapeutic services to persons with developmental disabilities;

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- Have staff who have experience working with persons with developmental disabilities;
- Screen, train, oversee and provide technical assistance to Host Home Families in accordance with OCDD requirements including the coordination of medical, behavioral and other professional services geared to persons with developmental disabilities; and
- Must provide on-going assistance to Host Home Families so that all HCBS waiver health and safety assurances, monitoring and critical incident reporting requirements are met.

Host Home Services (Provided to Adults)

Host Home Families who serve adults who have been interdicted must ensure that services are furnished in accordance with the legal requirements of the interdiction and must assist in providing information to supervisory authorities.

Host Home Families Employed Outside the Home

Host Home Families who are employed outside the home must adjust their employment/business duties/responsibilities to allow for the flexibility needed to meet their responsibilities to the recipient.

Companion Care Provider Responsibilities

Responsibilities of the Provider include:

- Assisting in the selection of companions who would be a suitable match for each recipient;
- Participating in the development of the recipient's POC;
- Facilitating in the development of the Recipient/Companion Agreement;
- Ensuring that the POC is being followed;
- Conducting an initial inspection as well as periodic inspections of the recipient's home;
- Providing all required training to companions, including any training specific to the special needs of the recipient;
- Contacting the companion a minimum of once per week or more if specified in the POC;
- Providing 24 hour oversight, back-up, and supervision of the companion care service;
- Providing emergency services; and
- Providing Companion Care relief supports (scheduled and unscheduled relief) during absences of the companion with the following guidelines:
 - Limited to 360 hours (15 days) per POC year as indicated in the POC;

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- Relief staff or scheduled and unscheduled absences are included in the Companion Care rate; and
- The Companion Care Provider is responsible for oversight, supervision, and back-up of the Companion Care service.

Responsibilities of the Companion

Responsibilities of the Companion include:

- Participating in the recipient's POC;
- Participating in the development of the Recipient/Companion Agreement;
- Following the POC and Recipient/Companion Agreement which includes:
 - Implementing the identified supports as indicated;
 - Assisting with activities of daily living as indicated;
 - Assisting the recipient in accessing community activities as indicated;
 - Being available as indicated and outlined in the pre-arranged time schedule as outlined;
 - Being available on short notice by telephone during crises situations as outlined; and
 - Coordinating transportation as needed; and
- Maintaining records in accordance with OCDD and provider requirements.

Shared Living Provider Responsibilities

In addition to the aforementioned responsibilities, Shared Living providers must also have OCDD approval which includes the following:

- Conversion Option:
 - Current ICF/DD provider in good standing and licensed to operate by DHH-Health Standards Section;
 - Apply for and meet ROW provider qualifications for the Shared Living Conversion; and
 - OCDD Regional Office or Human Services Authority or District will document that the Shared Living option was explained to, understood by and agreed upon by all individuals who will be affected when the ICF/DD is closed and the license is surrendered.
- New Option:
 - If any ICF/DD license is held or was previously held, the licensee must be or have been a provider in good standing; and
 - Apply for and meet ROW provider qualifications for the Shared Living.

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Day Habilitation Provider Responsibilities

The service provider must adhere to the following requirements in order to provide transportation to recipients:

- The provider’s vehicles used in transporting recipients must
 - Be in good repair,
 - Have a current Louisiana inspection sticker,
 - Have a first aid kit on board, and
 - Carry \$1,000,000 liability insurance.
- Drivers must have a current Louisiana driver’s license applicable to the vehicle being used, and
- The provider must document this service in the recipient’s record and the trip must be documented in the provider’s transportation log.

Supported Employment Provider Responsibilities

Supported Employment providers must maintain documentation in the file of each individual recipient that the services are not available to the recipient in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1401 (16) and (71).

The service provider must adhere to the following requirements in order to provide transportation to recipients:

- The provider’s vehicles used in transporting recipients must:
 - Be in good repair,
 - Have a current Louisiana inspection sticker, and
 - Have a first aid kit on board.
- Drivers must have a current Louisiana driver’s license applicable to the vehicle being used.
- The provider must document this service in the recipient’s record and the trip must be documented in the provider’s transportation log.

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Prevocational Provider Responsibilities

The provider must maintain documentation in the file of each individual recipient receiving Prevocational services that the services are not available to eligible recipients in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) 20 U.S.C. 1401 (16) and (71).

The service provider must adhere to the following requirements in order to provide transportation to recipients:

- The provider's vehicles used in transporting recipients must:
 - Be in good repair,
 - Have a current Louisiana inspection sticker, and
 - Have a first aid kit on board.
- Drivers must have a current Louisiana driver's license applicable to the vehicle being used.
- The provider must document this service in the recipient's record and the trip must be documented in the provider's transportation log.

Professional Services Provider Responsibilities (Psychological)

Providers of psychological services must:

- Perform an initial evaluation to assess the recipient's need for services,
- Develop an Individualized Service Plan for the provision of psychological services, which must document the supports that will be provided to the recipient to meet his/her goals based on the recipient's approved POC,
- Implement the recipient's therapy service plan in accordance with appropriate licensing and certification standards,
- Complete progress notes for each session, within ten days of the session, and provide notes to the recipient's support coordinator every three months or as specified in the POC,
- Maintain both current and past records and make them available upon request to OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or Legislative Auditors, and

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- Bill only for services rendered, based on the recipient's approved POC and Prior Authorization.

Nursing Services Provider Responsibilities

Provider agencies of Nursing Services must:

- Ensure that all nurses employed to provide Nursing services are either registered nurses or licensed practical nurses who have a current Louisiana Board of Nursing license with a minimum of one year of supervised nursing experience in providing Skilled Nursing services in a community setting to recipients.
- Provide an orientation on waiver services to licensed nurses and assure that licensed nurses adhere to the OCDD Critical Incident Reporting policy. (See Appendix D for information regarding this policy)
- Collect and submit the following documents to the recipient's support coordination agency:
 - Primary care physician's order for Nursing services. The physician's order must be signed, dated, and contain the number of hours per day and duration of Nursing services required to meet the recipient's needs. This order must be updated at least every 60 days. A copy of the physician's order must be sent to the support coordination agency prior to expiration of the previous approval to ensure continuation of services. The physician's order must be submitted to the OCDD Regional Waiver Office or Human Services Authority or District with the recipient's annual POC. Prior Authorization will not be released if the physician's order is not submitted as required.
 - Primary care physician's letter of necessity for Nursing services. The physician's letter of necessity must be on the physician's letterhead, identify all nursing duties to be performed by the nurse, and state the recipient's current medical condition and need for Nursing services.
 - Current Form 90-L signed by the recipient's primary care physician.
 - Summary of the recipient's medical history, which indicates the recipient's service needs, based on a documented record review and specifies any recent (within one year) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) extended home health approvals.
 - CMS Form 485 completed by the Home Health agency to identify the Skilled Nursing service needs.

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- Develop and implement an Individual Nursing Service Plan in conjunction with the recipient's physician, support team, and the support coordinator to identify and fulfill the recipient's specific needs in a cost-effective manner.
- Render services to the recipient as ordered by the recipient's primary care physician and as reflected in the recipient's POC within the requirements of the Louisiana Nurse Practice Act. For the purpose of this policy, nursing assessments, nursing care planning, and revisions of care planning must be consistent with the Outcome and Assessment Information Set (OASIS) requirements used by Home Health Agencies who provide Skilled Nursing services.
- Complete progress notes for each treatment, assessment, intervention, and critical incident.
- Provide the support coordination agency with physician-ordered changes every 60 days regarding the recipient's health status and health needs.
- Inform the support coordinator immediately of the providers' inability to provide staff according to the recipient's nursing service plan.
- Report any recipient's non-compliance with or refusal of the established Individual Nursing Service Plan, and provide these notes to the designated support coordinator every three months, or as specified in the POC.
- Maintain both current and past records and make them available upon request to the OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or legislative auditors.
- Bill for prior authorized services rendered based on the recipient's approved POC.
- Ensure the Home Health nurse and the recipient's support coordinator communicate at least monthly to determine if any further planning is required.
- Report any changes in the recipient's nursing service needs to the support coordinator. If necessary, the support coordinator will call an Interdisciplinary Team meeting to review the POC and to discuss any needed revisions. Changes which increase Nursing services in accordance with regulations, must revise the Individual Nursing Services Plan every 60 days.

NOTE: It is not necessary to revise the POC every 60 days unless there is a change in the recipient's medical condition requiring the need for additional Skilled Nursing services or the recipient requests a change.

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- Changes in the Individual Nursing Service Plan must be approved by the primary care physician and reflect the physician's orders for the Skilled Nursing service.
- Ensure the Individual Nursing Service Plan is current and available in the recipient's home at all times.
- Follow all ROW requirements, Minimum Standards for Home Health Agencies, and State and Federal rules and regulations for licensed Home Health Agencies and nursing care.
- Comply with OCDD standards for payment, Medical Assistance Program Integrity Law (MAPIL), Health Insurance Portability and Accountability Act (HIPAA), Americans with Disabilities Act (ADA), and licensing requirements.

STAFFING REQUIREMENTS

The Department of Health and Hospitals (DHH) has the responsibility to establish reasonable qualifications for providers to ensure that they are capable of providing services of acceptable quality to recipients. The provider qualifications delineated in this section are dictated by the needs of the population to be served, and by the duties and responsibilities inherent in the provision of services as defined by DHH. DHH has established these staffing requirements to maintain an adequate level of quality, efficiency, and professionalism in the provision of all services in the Residential Options Waiver (ROW) program.

The following exclusions apply to ROW services:

- Reimbursement shall not be paid for services furnished by a legally responsible relative. A legally responsible relative is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the recipient's spouse.
- Service may be provided by a member of the recipient's family, provided that the recipient does not live in the family member's residence and the family member is not the legally responsible relative as defined above.
- Family members who provide residential services must meet the same standards as providers or direct care staff who are unrelated to the individual.

Host Home (Substitute Family Care)

Immediate family members, such as a recipient's mother, father, brother, sister, spouse or curator, cannot be Substitute Family Care parents.

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RECORD KEEPING**Components of Record Keeping**

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

A separate record must be maintained on each recipient that fully documents services for which payments have been made. The provider must maintain sufficient documentation to enable DHH to verify that prior to payment each charge was due and proper. The provider must make available all records that DHH finds necessary to determine compliance with any federal or state law, rule, or regulation promulgated by DHH.

Confidentiality and Protection of Records

Records, including administrative and recipient, must be secured against loss, tampering, destruction, or unauthorized use. Providers must comply with the confidentiality standards as set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and in Louisiana Law.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, 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 wrongful disclosure of such information may result in the imposition by the DHH or whatever sanctions are available pursuant to Medicaid certification authority or the imposition of a monetary fine and/or imprisonment by the United States Government pursuant to the HIPAA Privacy Rule. 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
- Written consent of the parent or legal guardian when the recipient is a minor,

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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, or reasonably likely to endanger the life or physical safety of the recipient, that information may be withheld. This determination must be documented in writing.

The provider may charge a reasonable fee for providing the above records. The cost of copying 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 or the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted.

A system must be maintained that provides for the control and location of all recipient records. Recipient records must be located at the enrolled site. **Under no circumstances should providers allow staff to take recipient's case records from the facility.**

Review by State and Federal Agencies

Providers must make all administrative, personnel, and recipient records available to DHH and appropriate state and federal personnel at all reasonable times.

Retention of Records

The agency must retain administrative, personnel, and recipient records for whichever of the following time frames is longer:

- Until records are audited and all audit questions are answered

OR

- Five years from the date of the last payment period.

NOTE: Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements along with copies of the required documents transferred to the new agency. The new provider must bear the cost of copying, which cannot exceed the community's competitive copying rate.

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Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements and Medicaid enrollment agreements.

Recipient Records

A provider must have a separate written record for each recipient served by the agency. It is the responsibility of the provider to have adequate documentation of services offered to waiver recipients for the purposes of continuity of care, support for the individuals and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of services received and undertaken on behalf of the recipient.

Recipient records and location of documents within the record must be consistent among all records. Records must be appropriately maintained so that current material can be located in the record.

The OCDD does not prescribe a specific format for documentation, but must find all components outlined below in each recipient's active record.

Organization of Records, Record Entries and Corrections

The organization of individual recipient records and the 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:

- Name of the person making the entry,
- Signature of the person making the entry,
- Functional title of the person making the entry,
- Full date of documentation, and
- Supervisor review, if required.

Any error made by the staff 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.

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Components of Recipient Records

The recipient record must consist of the active record and the agency's storage files or folders. The active record must contain, *at a minimum*, the following information:

- Identifying information on the recipient that is recorded on a standardized form to include the following:
 - Name,
 - Home address,
 - Home telephone number,
 - Date of birth,
 - Sex,
 - List of current medications,
 - Primary and secondary disability,
 - Name and phone number of preferred hospital,
 - Closest living relative,
 - Marital status,
 - Name and address of current employment, school, or day program, as appropriate,
 - Date of initial contact,
 - Court and/or legal status, including relevant legal documents, if applicable,
 - Names, addresses, and phone numbers of other recipients or providers involved with the recipient's Plan of Care including the recipient's primary or attending physician,
 - Date this information was gathered, and
 - Signature of the staff member gathering the information.
- Documentation of the need for ongoing services,
- Medicaid eligibility information,
- A copy of assurances of freedom of choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc. signed by the recipient,
- Approved Plan of Care, including any revisions,
- Complete Individualized Service Plan (ISP),

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- Copy of all critical incident reports, if applicable,
- Formal grievances filed by the recipient,
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified in the Service Documentation below,
- Attendance records,
- Copy of the recipient’s behavior support plan, if applicable,
- Documentation of all interventions (medical, consultative, environmental and adaptive) used to ensure the recipient’s health, safety, and welfare,
- Reason for case closure and any agreements with the recipient at closure,
- Copies of all pertinent correspondence,
- At least six months (or all information if services provided less than 6 months) of current pertinent information relating to services provided,

NOTE: Records older than six months may be kept in storage files or folders, but must be available for review.

- Any threatening medical condition including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or any known allergies,
- Monitoring reports of waiver service providers to ensure that the services outlined in the Plan of Care are delivered as specified,
- Service logs describing all contacts, services delivered and/or action taken identifying the recipients involved in service delivery, the date and place of service, the content of service delivery and the services relation to the Plan of Care,
- A sign-out sheet that indicates the date and signature of the person(s) who viewed the record, and
- Any other pertinent documents.

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The provider must keep a separate record for each recipient being transported in the vehicle. At a minimum, this individual record should contain the following recipient information:

- Name,
- Telephone number,
- Address,
- Emergency contacts,
- Medicaid and/or Medicare insurance number and any other insurance card number,
- Current medications,
- Physician's name, telephone number and address,
- Preferred hospital,
- Current medical conditions including allergies, and
- Preferred religion (if stated).

After transportation has been provided, the recipient's transportation records must be returned to a secure, locked location in the provider agency. Recipient's transportation records must not be left in a vehicle.

Service Documentation

Support coordination agencies and direct service providers are responsible for documenting activities during the delivery of services. All documentation content and schedule requirements must be met by both support coordination agencies and direct service providers.

Required service documentation includes:

- Service logs,
- Progress notes,
- Progress summaries,

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- Discharge summaries for transfers and closures, and
- Individualized documentation.

NOTE: Direct service providers, who provide both waiver and state plan services, must maintain separate documentation for these services.

Service Logs

A service log provides a chronological listing of contacts and services provided to a recipient. They reflect the service delivered and document the services billed.

Federal requirements for documenting claims require the following information be entered on the service log to provide a clear audit trail:

- Name of recipient
- Name of provider and employee providing the service
- Service agency contact telephone number
- Date of service contact
- Start and stop time of service contact
- Place of service contact
- Purpose of service contact:
 - Personal outcomes addressed
 - Other issues addressed
- Content and outcome of service contact

There must be case record entries corresponding to each recorded support coordination and direct service provider activity which relates to one of the personal outcomes.

The service log entries need not be a narrative with every detail of the circumstances; however, all case notes must be clear as to who was contacted and what activity took place. Logs must be reviewed by the supervisor to insure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

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Services billed must clearly be related to the current Plan of Care.

Each support coordination service contact is to be briefly defined (i.e., telephone call, face-to-face visit) with a narrative in the form of a progress note. This documentation should support justification of critical support coordination elements for prior authorization of service in the Case Management Information System (CMIS).

Direct service providers must complete a narrative which reflects each entry into the payroll sheet and elaborates on the activity of the contact.

Progress Notes

Progress notes must be completed by both support coordinators and direct service providers at the time of each activity or service. Progress notes summarize the recipient’s day-to-day activities and demonstrate progress toward achieving his/her personal outcomes as identified in the approved Plan of Care. Progress notes must be of sufficient content to:

- Reflect descriptions of activities, procedures, and incidents,
- Give a picture of the service provided to the recipient,
- Show progress towards the recipient’s personal outcomes,
- Record any change in the recipient’s medical condition, behavior, or home situation which may indicate a need for reassessment and Plan of Care change,
- Record any changes or deviations from the typical weekly schedule in the recipient’s approved Plan of Care, and
- Reflect each entry in the service log and/or timesheet.

Checklists alone are not adequate documentation for progress notes.

The following are examples of general terms, when used alone, are not sufficient and do not reflect adequate content for progress notes:

- “Supported _____”
- “Assisted _____”
- “_____ is doing fine”

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- “_____ had a good day”
- “Prepared meals”

Progress notes must be reviewed by the supervisor to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

For recipients receiving formal training to learn a specific skill, progress notes must be paired with a skills training data sheet. In this instance, the progress notes must document the skills training occurred and should serve as a pointer to data collection mechanisms used.

Progress Summary

A progress summary is a synthesis of all activities for a specified period which address significant activities, progress toward the recipient’s desired personal outcomes, and changes in the recipient’s social history. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the recipient’s current Plan of Care, sufficient information for use by other support coordinators, direct service workers, or their supervisors, and evaluation of activities by program monitors. The progress summary in the service log may be used by the support coordinators and direct service providers to meet the documentation requirements.

A progress summary must be completed at least every quarter for each recipient.

Discharge Summary for Transfers and Closures

A discharge summary details the recipient’s progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a recipient’s discharge. The discharge summary in the service log may be used by the support coordinators and direct service providers to meet the documentation requirement.

Individualized Documentation

The support team must ensure that other documentation and data collection methods other than progress notes and progress and discharge summaries are considered so that appropriate measures are used to track the recipient’s progress toward his/her goals and objectives as specified in the approved Plan of Care.

For persons with behavioral, psychiatric, or medical risk factors, individualized documentation must be utilized as a means of tracking each key area of risk. This documentation is required, but not limited to, recipients with the following risk factors:

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- Seizure disorder and/or receiving seizure medication – Data forms used to track this information must include seizure reports. The support team may also need to consider assessing for the presence of side-effects of seizure medication on a monthly or quarterly basis.
- A medical issue which is significantly affected by or has a significant effect upon one's weight – Such issues may include diabetes, cardiovascular issues, medication side-effects, or receiving nutrition via g-tube, peg-tube, etc. Data forms used to track this information must include weight logs. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, and assessing for the presence of medication side-effects.
- Medications which can have severe side effects or potentially cause death if the adherence to medication management protocols is not strictly followed - Data forms used to track this information must include an assessment for the presence of medication side-effects on a monthly or quarterly basis. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, and tracking frequency/consistency of bowel movements with a daily bowel log.
- A psychiatric diagnosis and/or receiving psychotropic medication – Data forms used to track this information must include a psychiatric symptoms assessment. Based on the recipient's presenting symptoms, antecedents, and psychotropic medication guidelines, the support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, tracking frequency/intensity of challenging behaviors with a challenging behavior chart, and assessing for the presence of medication side-effects.
- Challenging behaviors which are severe or disruptive enough to warrant a behavioral treatment plan – Data forms used to track this information must include behavioral incident reports. The support team may also need to consider tracking frequency/intensity of psychiatric symptoms with a psychiatric symptoms assessment, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, and assessing for the presence of medication side-effects.

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The residential provider is responsible for collecting all required individualized documentation for the risk factors listed above and making it available to professionals, nursing, and medical personnel providing services to the recipient in order to facilitate quality of care. The data collection mechanism (e.g. the form or other collection method) related to these items must be submitted with the recipient’s Plan of Care and, if altered, with any succeeding revisions.

Schedule of Required Documentation

SUPPORT COORDINATION AGENCIES AND DIRECT SERVICE PROVIDERS			
SERVICE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/TRANSFER
At time of activity	At time of activity	At least every quarter.	Within 14 days of discharge

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SECTION 38.9: REIMBURSEMENT

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REIMBURSEMENT

Providers of Residential Options Waiver (ROW) services must utilize the Health Insurance Portability and Accountability Act compliant billing procedure code and modifier, when applicable. Refer to Appendix E for information about procedure code, unit of service and current reimbursement rates.

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

All claims for ROW services shall be filed by electronic claims submission 837P or on the CMS 1500 claim form.

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PROGRAM MONITORING

Services offered through the Residential Options Waiver (ROW) program are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal regulations. Medicaid's Health Standards Section (HSS) staff or its designee conducts on-site reviews of each provider agency. These reviews are conducted to monitor the provider agency's compliance with Medicaid's provider enrollment participation requirements, continued capacity for service delivery, quality and appropriateness of service provision to the waiver group, and the presence of the personal outcomes defined and prioritized by the individuals served.

The HSS reviews include a review of administrative records, personnel records, and a sample of recipient records. In addition, provider agencies are monitored with respect to:

- Recipient's access to needed services identified in the service plan,
- Quality of assessment and service planning,
- Appropriateness of services provided including content, intensity, frequency and recipient input and satisfaction,
- The presence of the personal outcomes as defined and prioritized by the recipient and/or responsible representative, and
- Internal quality improvement.

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

On-Site Reviews

On-site reviews with the provider agency are unannounced and conducted by HSS staff to:

- Ensure compliance with program requirements, and
- Ensure that services provided are appropriate to meet the needs of the recipients served.

Administrative Review

The Administrative Review includes:

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- A review of administrative records,
- A review of other provider agency documentation, and
- Provider agency staff interviews as well as interviews with a sampling of recipients 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, liquidated damages and/or recoupment of payment.

Interviews

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

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

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

Personnel Record Review

The Personnel Record Review includes:

- A review of personnel files,
- A review of time sheets, and
- A review of the current organizational chart.

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Recipient Record Review

A representative sample of recipient records are reviewed to ensure the services and supports delivered to recipients are rendered according to the recipient's approved Plan of Care (POC). The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the recipients served.

Recipient records are reviewed to ensure that the activities of the provider agency are correlated with the appropriate services of intake, ongoing assessment, planning (development of the POC), transition/closure, and that these activities are effective in assisting the recipient to attain or maintain the desired personal outcomes.

Documentation is reviewed to ensure that the services reimbursed were

- Identified in the POC,
- Provided,
- Documented properly,
- Appropriate in terms of frequency and intensity, and
- Relate back to personal outcomes on the POC.

Provider Staff Interviews

Provider agency staff is interviewed as part of the on-site review to ensure that staff meets the following qualifications:

- Education,
- Experience,
- Skills,
- Knowledge,
- Employment status,
- Hours worked,

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- Staff coverage,
- Supervisor to staff ratio,
- Caseload/recipient assignments,
- Supervision documentation, and
- Other applicable requirements.

Monitoring Report

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

The monitoring 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 reports 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.

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A follow-up monitoring survey will be conducted when deficiencies have been found to ensure that the provider has fully implemented the Plan of Correction. Follow up surveys may be conducted on-site or via evidence review.

Informal Dispute Resolution (Optional)

In the course of monitoring duties, an informal hearing process may be requested. 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 right of the provider to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix C for contact information.)

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

The provider is notified of the time and place of the informal hearing. 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 providers are given the opportunity to present their case and to explain their disagreement with the monitoring findings. The provider representatives are advised of the date to expect a written response and are reminded of their right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Department of Health and Hospitals' (DHH) Bureau of Appeals.

Fraud and Abuse

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

Quality Management

Direct service providers and support coordination agencies must have a quality enhancement process that involves:

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- Learning,
- Responding,
- Implementing, and
- Evaluating.

Agency quality enhancement activities must be reviewed and approved by the Office for Citizens with Developmental Disabilities regional office as described in the *Quality Enhancement Provider Handbook*. (See Appendix D for information on this handbook)

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SECTION 38.11: INCIDENTS, ACCIDENTS AND COMPLAINTS

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INCIDENTS, ACCIDENTS AND COMPLAINTS

The support coordination agency and direct service provider are responsible for ensuring the health and safety of the recipient. Support coordination and direct service staff must report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion to the on-duty supervisor immediately and as mandated by law to the appropriate agency. Reporting an incident only to a supervisor does not satisfy the legal requirement to report. The supervisor is responsible for ensuring that a report or referral is made to the appropriate agency.

All suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion must be reported to the appropriate authorities. (Refer to Appendix C for contact information)

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

Any other circumstances that place the recipient's health and well-being at risk should also be reported.

Support coordination agencies and direct service providers are responsible for documenting and maintaining records of **all** incidents and accidents involving the recipient. The Office for Citizens with Developmental Disabilities' *Critical Incident Reporting, Tracking and Follow-up Activities for Waiver Services* procedures must be followed for all reporting, tracking and follow-up activities of all critical incidents. Non-compliance shall result in administrative actions as indicated in this document. (See Appendix D for information on where to obtain a copy of this document)

Internal Complaint Policy

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

- Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint.

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- If the complaint is verbal, the provider staff member receiving the complaint must obtain and send all pertinent information in writing to the provider complaint coordinator. If the recipient completes the complaint form, he/she will be responsible for sending the form to the provider complaint coordinator.
- The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within five working days**.
- The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the recipient, the personal representative, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution.
- The provider's administrator or designee must inform the recipient and/or the personal representative in writing **within ten working days** of receipt of the complaint, the results of the internal investigation.
- If the recipient is dissatisfied with the results of the internal investigation regarding the complaint, he/she may continue the complaint resolution process by contacting the appropriate Office for Citizens with Developmental Disabilities (OCDD) Regional Waiver Office or Human Services Authority or District in writing, or by telephone.

If the complainant's name and address are known, the OCDD will notify the complainant **within two working days** that the complaint has been received and action on the complaint is being taken.

Complaint Disclosure Statement

La. R.S. 40:2009.13 - .21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the Home and Community-Based Services waiver programs. When the substance of the complaint is furnished to the service provider, it shall not identify the complainant or the recipient unless he/she consents in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

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The OCDD may determine when the complaint is initiated that a disclosure statement is necessary. If a Complainant Disclosure Statement is necessary, the complainant must be contacted and given an opportunity to withdraw the complaint.

If the complainant still elects to file the complaint, the OCDD will mail or FAX the disclosure form to the complainant with instructions to return it to the OCDD State Office.

Definition of Related Terms Regarding Incidents and Complaints

The following definitions are used in the incident and complaint process:

- Complaint - an allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a consumer or consumers (La. R.S. 40:2009.14)
- Minimal harm - is an incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the consumer's activities of daily living. (La. R.S. 40:2009.14)
- Trivial report - is an account of an allegation that an incident has occurred to a recipient or recipients that causes no physical or emotional harm and has no potential for causing harm to the recipient or recipients. (La. R.S. 40:2009.14)
- Allegation of noncompliance - is an accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (La. R.S. 40:2009.14)
- Abuse - is the infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well being is endangered. (La. R.S. 15:1503)
- Exploitation - is the illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of an aged persons or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 14:403.2)
- Extortion - is 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)

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- Neglect - is the failure, by a caregiver 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 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)
- Self-neglect - is the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)
- Sexual abuse - is any sexual activity between a recipient and staff without regard to consent or injury; any non-consensual sexual activity between a recipient and another person; or any sexual activity between a recipient and another recipient or any other person when the recipient is not competent to give consent. 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 competent to refuse.
- Disabled person - is a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for his/her own care or protection.
- Incident - any situation involving a recipient that is classified in one of the categories listed in this section, or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the recipient or affect delivery of waiver services.

DEVELOPMENTAL DISABILITY LAW

A developmental disability is defined by the Developmental Disability Law (Louisiana Revised Statutes 28:451.1-28:455.2). The law states that a developmental disability means either:

- a. A severe chronic disability of a person that:
- Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.
 - Is manifested before the person reaches age twenty-two.
 - Is likely to continue indefinitely.
 - Results in substantial functional limitations in three or more of the following areas of major life activity:
 - Self-care.
 - Receptive and expressive language.
 - Learning.
 - Mobility.
 - Self-direction.
 - Capacity for independent living.
 - Economic self-sufficiency.
 - Is not attributed solely to mental illness.
 - Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

OR

- b. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria in Subparagraph (a) of this Paragraph later in life that may be considered to be a developmental disability.

GLOSSARY

The following is a list of abbreviations, acronyms and definitions used in the Residential Options Waiver (ROW) manual chapter.

Abuse (adult/elderly) – The infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (Louisiana Revised Statutes 15:1503)

Abuse (child) – Any of the following acts which seriously endanger the physical, mental, or emotional health and safety of the child including:

- The infliction or attempted infliction, or as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon the child by a parent or by any other person.
- The exploitation or overwork of a child by a parent or by any other person.
- The involvement of a child in any sexual act with a parent or with any other person, or the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, or the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code, Article 1003).

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

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

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

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

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

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Authorized Representative – A person designated by a recipient (by use of a designation form) to act on his/her behalf with respect to his/her services.

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

BPS – Bureau of Protective Services

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services responsible for Federal administration of the Medicaid, Medicare, and State Children’s Health Insurance Program (SCHIP) programs.

Change of Ownership (CHOW) – Any change in the legal entity responsible for operation of a provider agency.

Claim – A request for payment for services rendered.

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

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) Privacy Rule and by Louisiana law..

Corrective Action Plan – Written description of action a direct service provider agency plans to take to correct deficiencies identified by the Office for Citizens with Developmental Disabilities (OCDD) or DHH.

Critical Incident – An alleged, suspected or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.

De-certification – Removal of a recipient from the waiver by OCDD due to the inability of waiver services to ensure a recipient’s health and safety in the community or due to non-compliance with waiver requirements by the recipient. Decertification of a waiver recipient is subject to review by the State Office Review panel prior to notification of appeal rights and subsequent termination of waiver services.

Department of Health and Hospitals (DHH) – The state agency responsible for administering the state’s Medicaid programs and other health and related services including public health, mental health, developmental disabilities, and addictive disorder services.

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Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and other health programs.

Developmental Disability – See Appendix A

Diagnosis and Evaluation (D&E) – A process conducted by an appropriate professional to determine a person’s level of disability and to make recommendations for remediation.

Direct Service Provider (DSP) – A public or private licensed organization/entity that is enrolled as a Medicaid provider to furnish services to recipients using its own employees (direct support workers).

Direct Support Worker (DSW) – A person who is paid to provide direct services and active supports to a recipient.

Discharge – A recipient’s removal from the waiver for reasons established by OCDD.

Durable Medical Equipment (DME) – Durable medical equipment covered under the Medicaid State Plan.

Eligibility – The determination of whether or not a person qualifies to receive waiver services based on meeting established criteria for the target group as set by DHH.

Emergency Backup Plan – Provision of alternative arrangements for the delivery of services that are critical to a recipient’s well-being in the event that the direct service worker responsible for furnishing the services fails or is unable to deliver them.

Exploitation – The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of the person’s or disabled adult's power of attorney or guardianship for one's own profit or advantage. (Louisiana Revised Statutes 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.

Fiscal/Employer Agent (F/EA) – A term used by the Internal Revenue Service (IRS) for entities that perform tax withholding for employers.

Force Majeure – An event or effect that cannot be reasonably anticipated or controlled.

Freedom of Choice (FOC) – The process that allows a recipient the choice between institutional or home and community based services and to review all available support coordination and service provider agencies in order to freely select agencies of his/her choice.

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Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule – A Federal regulation designed to provide privacy standards to protect patient’s medical records and other health information provided to health plans, doctors, hospitals, and other healthcare providers.

Home and Community-Based Services (HCBS) – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirement of an institutional level of care. It provides a collection of supports and services available through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services.

Individual Budget – An amount of dollars over which the recipient or his/her authorized representative exercises decision-making authority concerning the selection of services, service providers, and the amount of services (self-direction option).

Individualized Service Plan (ISP) – A written agreement developed by a service provider that specifies the long-range goals, short-term objectives, specific strategies or action steps, assignment of responsibility, and timeframes for meeting the recipient’s personal outcomes as specified in his/her approved Plan of Care.

Institutionalization – The placement of a recipient in an inpatient facility including a hospital, group home for people with developmental disabilities, nursing facility, or psychiatric hospital.

Intermediate Care Facility for People with Developmental Disabilities (ICF/DD) – A public or private facility that provides health and habilitation services to people with developmental disabilities. ICFs/DD have four or more beds and provide “active treatment” to their residents.

Level of Care (LOC) – The specification of the minimum amount of assistance that a person must require in order to receive services in an institutional setting under the Medicaid State Plan.

Licensure – A determination by the Medicaid Health Standards Section that a service provider agency meets the requirements of State law to provide services.

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

Louisiana Rehabilitation Services (LRS) – The agency under the Louisiana Workforce Commission charged with providing vocational rehabilitation services to qualified persons.

LTC – Long Term Care.

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Medicaid – A federal-state medical assistance entitlement program provided under a State plan approved under Title XIX of the Social Security Act.

Medicaid Eligibility Determination (Form 90-L) – The form that is signed by a Louisiana licensed physician and used by Medicaid to establish a Level of Care (LOC). In the Waiver programs, a recipient must meet an ICF/DD LOC in order to be offered a waiver opportunity.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the DHH. (LA RS 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. The system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

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.15:1503).

Monitoring – The ongoing oversight of the provision of waiver services to ensure that they are furnished according to the recipient’s Plan of Care and effectively meet his/her needs.

Multi-disciplinary Team (MDT) – The group of professionals involved in assessing the needs of a high risk recipient and making recommendations in a team staffing for services or interventions targeted at those needs.

Native Language – The language normally used by the recipient and his/her support network, which may include American or English Sign Language and other non-verbal forms of communication.

Natural Supports – Persons who are not paid to assist a recipient in achieving his/her personal outcomes regardless of their relationship to the recipient.

Neglect (adult/elderly) – The failure of a care giver who is responsible for an adult's care or by other parties, or by the adult recipient’s action or inaction 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. (Louisiana Revised Statutes 15:1503).

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Neglect (child) – The refusal or failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment or counseling for an injury, illness, or condition of the child, as a result of which the child’s physical, mental, or emotional health and safety is substantially threatened or impaired. Whenever, in lieu of medical care, a child is being provided treatment in accordance with the tenets of a well – recognized religious method of healing which has a reasonable, proven record of success, the child shall not, for that reason alone, be considered neglected or abused. Disagreement by the parents regarding the need for medical care, shall not by itself, be grounds for termination of parental rights. (Children’s Code Article 1003).

Office for Citizens with Developmental Disabilities (OCDD) – The operating agency responsible for the day-to-day operation and administration of the OCDD Waiver programs.

Outcome – The result of performance (or non-performance) of a function or process.

Person-Centered Planning – A Plan of Care process directed and led by the recipient or his/her authorized representative designed to identify his/her strengths, capacities, preferences, needs, and desired outcomes.

Personal Outcomes – Results achieved by or for the waiver recipient through the provision of services and supports that make a meaningful difference in the quality of his/her life.

Plan of Care – A written plan designed by the recipient, his/her authorized representative, service provider(s), and others chosen by the recipient, and facilitated by the support coordinator which lists all paid and unpaid supports and services. It also identifies broad goals and timelines identified by the recipient as necessary to achieve his/her personal outcomes.

Plan of Correction – A plan developed by a provider in response to deficient practice citations. Required components of the Plan of Correction include the following:

- What corrective actions will be accomplished for those waiver recipients found to have been affected by the deficient practice;
- How other recipients being provided services and support who have the potential to be affected by the deficient practice will be provided corrective care resulting from the Plan of Correction;
- The measures that will be put into place or the systemic changes that will be made to ensure that the deficient practice will not recur; and
- How the corrective measures will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place regarding the identified deficient practice.

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Pre-certification Visit – The visit the OCDD regional waiver office or Human Services District or Authority makes to the residence of the applicant, where at a minimum the applicant and, if appropriate, his/her representative(s) are in attendance in order to ensure that waiver planning and services, rights, responsibilities, methods of filing grievances and/or complaints, abuse/neglect and possible means of relief have been fully explained and that all parties are in agreement to move forward with waiver services.

Prior and Post Authorization (PA) - The authorization for service delivery based on the recipient's approved Plan of Care. Prior authorization must be obtained before any waiver services can be provided and post authorization must be approved before services delivered will be paid.

Procedure Code – A code used to identify a service or procedure performed by a provider.

Provider/Provider Agency – An individual or entity furnishing Medicaid services under a provider and/or licensing or certification agreement.

Quality Assurance/Quality Enhancement (QA/QE) Program: - A program that assesses and improves the equity, effectiveness and efficiency of waiver services in a fiscally responsible system with a focus on the promotion and attainment of independence, inclusion, individuality and productivity of persons receiving waiver services and accomplishes these goals through standardized and comprehensive evaluations, analyses and special studies.

Quality Enhancement – The section within the OCDD whose responsibilities include the activities to promote the provision of effective services and supports on behalf of recipients and to assure their health and welfare. Quality enhancement activities ensure that program standards and requirements are met.

Quality Improvement (QI) – The performance of discovery, remediation, and quality improvement activities in order to ascertain whether the service provider agency meets assurances, corrects shortcomings, and pursues opportunities for improvement.

Reassessment – A core element of services defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and redesigning the overall Plan of Care.

Recipient – An individual who has been certified for medical benefits by the Medicaid Program. A recipient certified for Medicaid waiver services may also be referred to as a participant.

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.

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Request for Services Registry (RFSR) – A registry maintained by the OCDD that includes the dates of request and the names of individuals who have been determined to meet the Louisiana definition for developmental disability and wish to receive services in a waiver program.

Residential Options Waiver (ROW) – A 1915(c) waiver designed to provide home and community-based services to recipients who otherwise would require the level of care of an ICF/DD.

Self-Neglect – Is the failure, either by the adult’s action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected (Louisiana Revised Statutes 15:1503).

Sexual Abuse – Is any sexual activity between a recipient and staff without regard to consent or injury; any non-consensual sexual activity between a recipient and another person, or any sexual activity between a recipient and another recipient, or any other person when the recipient is not competent to give consent. 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 competent to refuse.

Single Point of Entry (SPOE) – The OCDD regional offices, Human Service Authorities and Human Service Districts where the entry point for all developmental disability services, including home and community-based waivers, is made.

SOA – Statement of Approval (previously known as a Statement of Eligibility or SOE). Statement issued by the SPOE confirming the date the individual has been determined to meet the Louisiana definition for developmental disability.

Support Coordination – Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational and other support services. Activities include assessment, Plan of Care development, service monitoring, and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources.

Support Coordinator – An individual meeting qualifications required by DHH who is employed by a qualified Support Coordination Agency that provides support coordination services.

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Support Team – A team comprised of the recipient, the recipient’s legal representative(s), family members, friends, support coordinator, direct service providers, medical and social work professionals as necessary, and other advocates, who assist the recipient in determining needed supports and services to meet the recipient’s identified personal outcomes. Medical and social work professionals may participate by report. All other support team members must be active recipients.

Surveillance Utilization Review System (SURS) – The program operated by the DHH Fiscal Intermediary in partnership with the Program Integrity Section, which reviews provider’s compliance with Louisiana Medicaid policies and regulations, including investigating allegations of excessive billing.

Title XIX – The section of the Social Security Act, which authorizes the Medicaid Program.

Transition – The steps or activities conducted to support the passage of the recipient from existing formal or informal services to the appropriate level of services, including disengagement from all services.

Waiver – An optional Medicaid program established under Section 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care.

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OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Department of Health and Hospitals - Health Standards Section	Office to contact to report changes that affect provider license	DHH/Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 or (225) 342-0138 Fax: (225) 342-5292
Division of Administrative Law – Health and Hospitals Section	Office to contact to file an appeal request	Division of Administrative Law - Health and Hospitals Section P. O. Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 Fax: (225) 219-9823 Phone for oral appeals: (225) 342-5800
Provider Enrollment Section	Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer	Molina Medicaid Solutions Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370
Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information	Molina Medicaid Solutions Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783
Office of Community Services - Local Child Protection Hotline	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a recipient under the age of 18	Refer to the Department of Children and Family Services website at: http://www.dss.la.gov under the “Report Child Abuse/Neglect” link
Adult Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a recipient age 18 or over or an emancipated minor	Department of Health and Hospitals Office of Aging and Adult Services 1-800-898-4910

Office for Citizens with Developmental Disabilities (OCDD)

Contact information for the central office and the regional local governing entities (LGEs) is found on the OCDD website at: <http://dhh.louisiana.gov/index.cfm/page/134/n/137>

FORMS/WEBSITES

1. Forms used in the Residential Options Waiver program can be obtained from the DHH website at:

<http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1564>

2. The OCDD *Critical Incident Reporting for Waiver Services* can be obtained from the DHH website at

<http://new.dhh.louisiana.gov/index.cfm/page/137/n/140>

3. The *Quality Enhancement Provider Handbook* can be obtained from the DHH website at

<http://new.dhh.louisiana.gov/assets/docs/OCDD/waiver/QEProviderHandbook080108.pdf>

4. The *Request for Taxpayer Identification Number and Certification* (W-9) form and instructions can be obtained from the IRS website at

<http://www.irs.gov/pub/irs-pdf/fw9.pdf> and <http://www.irs.gov/pub/irs-pdf/iw9.pdf>

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APPENDIX E: BILLING CODES

BILLING CODES

The following chart describes the codes and rates that are to be used with the Residential Options Waiver. Providers must bill the appropriate procedure code for the service performed.

HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Support Coordination										
Case Management	45	81	4W	Support Coordination	T1016			\$ 135.99	1 flat monthly	12 annually
Transition Funding										
Community Transition Waiver	2	4A		One time transition service	T2038			\$3000		Life time maximum limit
Community Living Supports (Residential)										
Attendant Care Services	82	82	4W	Community Living Supports – 1 Person	S5125			\$ 4.00	15 min	
Attendant Care Services	82	82	4W	Community Living Supports – 2 Persons	S5125	UN		\$ 3.00	15 min	
Attendant Care Services	82	82	4W	Community Living Supports – 3 persons	S5125	UP		\$ 2.50	15 min	
Host Home Services-Children under 18 (Residential)										
Foster Care	84	84	4W	Host Home Level 1	S5140	HA		\$ 52.95	Per diem	
Foster Care	84	84	4W	Host Home Level 2	S5140	TF	HA	\$ 57.05	Per diem	
Foster Care	84	84	4W	Host Home Level 3	S5140	TG	HA	\$ 64.11	Per diem	
Foster Care	84	84	4W	Host Home Level 4	S5140	U2	HA	\$ 68.95	Per diem	

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HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Host Home Services-Adults 18 and over (Residential)										
Foster Care Adult	84	84	4W	Host Home Level 1	S5140			\$ 52.67	Per diem	
Foster Care Adult	84	84	4W	Host Home Level 2	S5140	TF		\$ 57.05	Per diem	
Foster Care Adult	84	84	4W	Host Home Level 3	S5140	TG		\$ 64.11	Per diem	
Foster Care Adult	84	84	4W	Host Home Level 4	S5140	U2		\$ 69.32	Per diem	
Companion Care Services (Residential)										
Companion Care, Adult	82	82	4W	Companion Care	S5136			\$ 92.02	Per diem	
Shared Living Services-New (Up to 3 people) Provider Leased or Owned Residence (Residential)										
Habilitation, Residential	11	4A	4G	Shared Living – Level 1	T2016			\$ 82.33	Per diem	
Habilitation Residential	11	4A	4G	Shared Living – Level 2	T2016	TF	HQ	\$ 90.81	Per diem	
Habilitation Residential	11	4A	4G	Shared Living – Level 3	T2016	TG	HQ	\$ 104.08	Per diem	
Habilitation Residential	11	4A	4G	Shared Living – Level 4	T2016	U2	HQ	\$ 123.09	Per diem	
Shared Living-New (Up to 3 people) Participant Leased or Owned Residence (Residential)										
Habilitation, Residential	11	4A	4L	Shared Living – Level 1	T2016	HQ		\$ 82.33	Per diem	
Habilitation Residential	11	4A	4L	Shared Living – Level 2	T2016	TF	HQ	\$ 90.81	Per diem	

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HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Shared Living-New (Up to 3 people)										
Participant Leased or Owned Residence (Residential) continued										
Habilitation Residential	11	4A	4L	Shared Living – Level 3	T2016	TG	HQ	\$ 104.08	Per diem	
Habilitation Residential	11	4A	4L	Shared Living – Level 4	T2016	U2	HQ	\$ 123.09	Per diem	
Shared Living-Conversion/Provider Leased or Owned Residence (Residential)										
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 1 Up to 4 people	T2033	UQ		\$ 61.81	Per diem	
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 2 Up to 4 people	T2033	TF	UQ	\$ 70.09	Per diem	
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 3 Up to 4 people	T2033	TG	UQ	\$ 84.86	Per diem	
Residential Care, (NOS), Waiver	11	4A	4J	Shared Living – Level 4 Up to 4 people	T2033	U2	UQ	\$ 111.26	Per diem	
Shared Living-Conversion/Participant Leased or Owned Residence (Residential)										
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 1 Up to 4 people	T2033	UQ		\$ 61.81	Per diem	
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 2 Up to 4 people	T2033	TF	UQ	\$ 70.09	Per diem	
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 3 Up to 4 people	T2033	TG	UQ	\$ 84.86	Per diem	
Residential Care, (NOS), Waiver	11	4A	4H	Shared Living – Level 4 Up to 4 people	T2033	U2	UQ	\$ 111.26	Per diem	

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HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Respite Services										
Respite Care Services	83	83		Respite Care Services- Out of Home	T1005	HQ		\$ 3.50	15 min	720 hours
Personal Emergency Response System										
Personal Emergency Response System	16	90		Installation	S5160			\$30.00	Installation	
Personal Emergency Response System	16	90		Monthly Service Fee	S5161			\$27.00	Monthly	

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HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Transportation (Residential Services)										
Transportation Local Trip	42	4X	4W	Transportation Regular - (Comm Access)	Z5177			\$5.58	One-way	730
		4A								
Transportation -Local Trip (W/C)	42	4X	4W	Transportation Wheel chair – (Comm Access)	Z5186			\$9.32	One-way	730
		4A								
Adaptation/Accessibility Services										
Assistive Technology/ Specialized Medical Equipment	17	91		Assistive Technology Specialized Medical Equip. and Supplies	T2029				Per Item/ Service	
Specialized Medical Equipment, Not otherwise specified (NOS)	17	91		Repairs Specialized Medical Equipment and Assistive Technology	T2029	RB			Per Item/ Repair	
Environmental Modifications	15	80		Environmental Accessibility Adaptations	Z0620				Per Service	
Vocational Services										
Supported Employment	98	98		Supported Employment, Individual Job and Assistance with Micro Enterprise	H2023	TT		\$ 2.60	15 min (Minimum number of service hours is 1 hour)	32 units per day
Supported Employment	98	98		Supported Employment, Mobile Crew or Enclave	H2024	52		\$ 26.00	2.5 hours	2 units per day
Non-Emergency Transportation	98	98		Regular Transportation for Supported Employment Services	T2003	SE		\$ 6.00	One way	
Non-Emergency Transportation	98	98		Wheel chair Transportation for Supported Employment Services	A0130	SE		\$ 10.00	One way	
Habilitation, Prevocational	13	36		Pre-Vocational	T2014	52		\$ 22.50	2.5 hours	10 units per week
Non-Emergency Transportation	13	36		Regular Transportation for Prevocational Services	T2003			\$ 6.00	One way	10 units per week

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HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Vocational Services (continued)										
Non-Emergency Transportation	13	36		Wheel chair Transportation for Prevocational Services	A0130			\$ 10.00	One way	10 units per week
Day Habilitation	14	50		Day Habilitation	T2020			\$ 18.50	2.5 hours	10 units per week
Non-Emergency Transportation	14	50		Regular Transportation for Day Habilitation	T2003	U6		\$ 6.00	One way	10 units per week
Non-Emergency Transportation	14	50		Wheel chair Transportation for Day Habilitation	A0130	U6		\$ 10.00	One way	10 units per week
Nursing Services										
In Home Nursing Care by LPN	44	87	4W	LPN-Intermittent Services (1 person)	G0300			\$ 54.92	Per visit	
	11	4A								
Services of Skilled Nurse In Home Health Setting	44	87	4W	LPN-Intermittent Services (up to 4 persons)	G0300	TT		\$ 27.46	Per visit	
	11	4A								
In Home Nursing Care by LPN	44	87	4W	LPN-Extended Services (1 person)	S9124			\$ 32.00	Per hour	
	11	4A								
In Home Nursing Care by LPN	44	87	4W	LPN-Extended Services (up to 2 persons)	S9124	TT		\$ 16.00	Per Hour	
	11	4A								
RN Intermittent Services	44	87	4W	Nursing RN (1 person)	G0299			\$ 68.85	Per visit	
	11	4A								
RN Extended Services	44	87	4W	Nursing RN (up to 2 persons)	S9123	TT		\$ 17.00	Per hour	
	11	4A								
RN Extended Services	44	87	4W	Nursing RN (1 person)	S9123			\$ 34.00	Per hour	
	11	4A								
RN Intermittent Services	44	87	4W	Nursing RN (up to 4 persons)	G0299	TT		\$ 34.32	Per visit	
	11	4A								

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Professional Services (Registered Dietician)										
Professional Services	41,11, 84	4R	4W	Registered Dietician (Individual)	97802			\$ 9.00	15 min	
Professional Services	41,11, 84	4R	4W	Registered Dietician (Individual, Subsequent)	97803			\$ 9.00	15 min	
Professional Services	41,11, 84	4R	4W	Registered Dietician (Group)	97804			\$ 9.00	15 min	
Professional Services (Speech Therapy)										
Professional Services	39	71	4W	Speech Therapy Evaluation of Speech Fluency (e.g. stuttering, cluttering)	92521			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy Evaluation of Speech sound production (e.g. articulation, phonological process, apraxia, dysarthria)	92522			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy Evaluation of Speech Sound Production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language)	92523			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy Behavioral and Qualitative Analysis of Voice and Resonance	92524			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Speech Language Hearing Therapy)	92507			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Laryngeal function studies)	92520			\$ 21.00	15 min	
	11	4A								
	84	84								

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Professional Services (Speech Therapy) continued										
Professional Services	39	71	4W	Speech Therapy (Oral function therapy)	92526			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Evaluation for non-speech device RX)	92605			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Non-speech device service)	92606			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Ex for speech device RX)	92607			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Evaluate swallowing function)	92610			\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Therapeutic activities)	97530	GN		\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services	39	71	4W	Speech Therapy (Cognitive skills development)	97129	GN		\$ 21.00	15 min	
	11	4A								
	84	84								
Professional Services (Occupational Therapy)										
Professional Services	37	74	4W	Occupational Therapy (OT Evaluation low complex 30 min)	97165			\$44.40	30 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT Evaluation mod complex 45min)	97166			\$66.60	45 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT Evaluation high complex 60 min)	97167			\$88.80	60 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT re-evaluation est plan of care)	97168			\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of hot or cold packs)	97010	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of Traction, Mechanical)	97012	GO		\$ 23.00	15 min	
	11	4A								
	84	84								

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Professional Services (Occupational Therapy) continued										
Professional Services	37	74	4W	Occupational Therapy (Application of electrical stimulation/ unattended)	97014	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of paraffin bath)	97018	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of whirlpool)	97022	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of electrical stimulation/ manual)	97032	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of iontophoresis)	97033	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Application of ultrasound)	97035	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (OT Therapeutic Procedure)	97110	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Massage therapy)	97124	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Manual therapy)	97140	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Therapeutic activities)	97530	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Cognitive skills development)	97129	GO		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	37	74	4W	Occupational Therapy (Wheelchair management)	97542	GO		\$ 23.00	15 min	
	11	4A								
	84	84								

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Professional Services (Physical Therapy)										
Professional Services	35	65	4W	Physical Therapy (PT Evaluation low complex 20 min)	97161			\$29.60	20 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (PT Evaluation mod complex 30 min)	97162			\$44.40	30 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (PT Evaluation high complex 45 min)	97163			\$66.60	45 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (PT re-evaluation est plan of care)	97164			\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of hot or cold packs)	97010	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of traction, mechanical)	97012	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of electrical stimulation/ unattended)	97014	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of paraffin bath)	97018	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of whirlpool)	97022	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of electrical stimulation/ manual)	97032	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of Iontophoresis)	97033	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Application of ultrasound)	97035	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Therapeutic Procedure)	97110	GP		\$ 23.00	15 min	
	11	4A								
	84	84								

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Professional Services (Physical Therapy) continued										
Professional Services	35	65	4W	Physical Therapy (neuromuscular re-education)	97112			\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Gait training)	97116			\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Massage therapy)	97124	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Manual therapy)	97140	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Therapeutic activities)	97530	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services	35	65	4W	Physical Therapy (Wheelchair Management)	97542	GP		\$ 23.00	15 min	
	11	4A								
	84	84								
Professional Services (Social Work)										
Professional Services	73	73	4W	Social Worker (Family psychotherapy)	90847	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Group psychotherapy)	90853	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Self-care Management Training)	97535	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Community/ Work Reintegration)	97537	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Home visit assistance w/ADL's and personal care)	99509	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								

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Professional Services (Social Work) continued										
Professional Services	73	73	4W	Social Worker (Home Visit, Sing/M/Fam Counseling)	99510	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Unlisted Home Visit Service or Procedure)	99600	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (HHCP-SVS of CSW)	G0155			\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Assertive Community treatment face to face)	H0039	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Mental Health Services, NOS)	H0046	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Crisis Intervention)	H2011	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Skilled Training and Development)	H2014			\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Psychosocial Rehab Services)	H2017	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Therapeutic Behavior Service)	H2019	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services	73	73	4W	Social Worker (Community-based Wrap Around)	H2021	AJ		\$ 18.00	15 min	
	11	4A								
	84	84								
Professional Services (Psychology)										
Professional Services	31	62, 95,96		Psychologist (Interactive Psychological Diagnostic Interview)	90791			\$ 31.25	15 min	
	11	4A								
	84	84								

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Professional Services (Psychology) continued										
Professional Services	31	62, 95,96	4W	Psychologist (Individual Psychotherapy)	90832			\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Family therapy without patient present)	90846			\$ 31.25	15 min	
	11	4A								
	84	84								
	31	62, 95,96	4W	Psychologist (Special Family Therapy w/ patient)	90847	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Group Psychotherapy)	90853	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Pharmacologic Management)	90863			\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Psychological Testing by Psychologist)	96130			\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Psychological Testing by Tech)	96138			\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Neuropsychological testing)	96132			\$ 31.25	15 min	
	11	4A								
	84	84								
HIPAA CODE NAME	PROVIDER TYPE	PROVIDER SPEC	PROVIDER SUB-SPECIALTY	SERVICE DESCRIPTION	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	RATE	STANDARD UNIT OF SERVICE	ANNUAL SERVICE LIMITS
Professional Services (Psychology) continued										
Professional Services	31	62, 95,96	4W	Psychologist (Self-care Management Training)	97535	AH		\$ 31.25	15 min	
	11	4A								
	84	84								

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Professional Services	31	62, 95,96	4W	Psychologist (Community/ Work Reintegration)	97537	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Home visit for Assistance with ADL's and Personal Care)	99509	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Home Visit, Sing/M/Fam Counseling)	99510	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Unlisted Home Visit Service or Procedure)	99600	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Assertive Community Treatment Face to Face)	H0039	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Mental Health Services, NOS)	H0046	AH		31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Crisis Intervention)	H2011	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Psychosocial Rehab Services)	H2017	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Therapeutic Behavior Service)	H2019	AH		\$ 31.25	15 min	
	11	4A								
	84	84								
Professional Services	31	62, 95,96	4W	Psychologist (Community-based Wrap Around)	H2021	AH		\$ 31.25	15 min	
	11	4A								
	84	84								

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Dental Services										
Dental	27	19, 66, 67, 68		Dental (Periodic Oral Examination, Patient of Record)	D0120			\$ 32.06	Per procedure	
Dental	27	19, 66, 67, 68		Dental (Comprehensive Oral Examination, New Patient)	D0150			\$ 55.37	Per procedure	
Dental	27	19, 66, 67, 68		Dental (Radiographs, Complete Series including Bitewings)	D0210			\$ 70.15	Per procedure	
Dental	27	19, 66, 67, 68		Dental (Prohylaxis-Adult)	D1110			\$ 54.64	Per procedure	
Permanent Supportive Housing Supports										
Permanent Supportive Housing	AW			Housing Stabilization	Z0648			\$15.11	15 Min.	72 units annually
								\$60.44	1 Hour	
Permanent Supportive Housing	AW			Housing Stabilization Transition	Z0649			\$15.11	15 Min.	93 units annually
								\$60.44	1 Hour	
Adult Day Health Care (ADHC) Service										
Medical Rehabilitation Day Program	85	35	4W	Adult Day Health Care Center Based Service (ADHC)	S5100			\$2.78 Rate includes provider specific transportation rate	15 min	Max 40 unit per day
Monitored In-Home Care Giving										
Monitored In-Home Care Giving	MI	35		Waiver Service - not otherwise specified Level 1	T2033			\$59.60	per diem	
Monitored In-Home Care Giving	MI	35		Waiver Service - not otherwise specified Level 2	T2033	TG		\$89.40	per diem	
Monitored In-Home Care Giving	MI	35		Assessment	T1028	TU		\$250.00	one time	