



SUPPORTS WAIVER PROVIDER MANUAL

Chapter Forty-three of the Medicaid Services Manual

Issued June 10, 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 Supports Waiver (SW) is a 1915(c) waiver designed to enhance the home and community-based supports and services available to beneficiaries with developmental disabilities who require the level of care of an Intermediate Care Facility for the Developmentally Disabled (ICF/ID). The SW is funded by the Centers for Medicare and Medicaid Services (CMS), a federal agency, and matching state dollars. The waiver is operated by the Office for Citizens with Developmental Disabilities (OCDD) under the authorization of the Bureau of Health Services Financing (BHSF), both of which are under the Louisiana Department of Health (LDH).

The mission of the SW is to create options and provide meaningful opportunities for those individuals, 18 years of age and older who have a developmental disability, through vocational and community inclusion. The SW is available to provide the supports necessary in order for individuals to achieve their desired community living and work experience by providing the services needed to acquire, retain, and/or improve self-help, socialization and adaptive skills as well as providing the beneficiary an opportunity to contribute to his/her community.

The objectives of the SW are to:

- Promote independence for beneficiaries through the provision of services, which meet the highest standard of quality and are based on national best practices, while ensuring their health and welfare through a comprehensive system of safeguards;
- Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing (not replacing) existing informal networks;
- Support beneficiaries and their families to exercise their rights and share responsibility for their programs, regardless of the service delivery method;
- Offer access to services on a short-term basis that would protect the health and welfare of beneficiaries if their families or caregivers are unable to continue to provide care and supervision; and
- Increase high school to community transition resources by offering supports and services to those 18 years and older.

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The SW includes the following services: Supported Employment, Day Habilitation, Prevocational, Habilitation, Respite, Housing Stabilization Transition, Housing Stabilization, Personal Emergency Response System, and Support Coordination. These services are further defined in this chapter.

Services provided in the SW program must comply with the CMS Home and Community Based Services (HCBS) Settings Final Rule 42 CFR441.530. Any residential or non-residential setting where individuals live and/or receive HCBS must demonstrate the following:

- Integrated in and supports full access of individuals to the greater community
 - Provides opportunities to seek employment, work in competitive integrated settings, engage in community life, control personal resources; and
 - Ensures that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.
- Selected by the individual from among setting options including non-disability specific settings and options for a private unit in a residential setting.
 - Person-centered service plan documents options based on the individual's needs, preferences, and for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports and who provides them.

Beneficiaries have a choice of available Support Coordination (SC) agencies and provider agencies and are able to select enrolled qualified agencies through the Freedom of Choice (FOC) process. The Plan of Care (POC) is developed using a person-centered planning process and identifies all of a beneficiary's needs, both non-funded and funded.

All natural supports, available community resources, and applicable Medicaid State Plan services must be exhausted prior to utilization of waiver funding. Also, the beneficiary must apply for, and exhaust any similar services available through Louisiana Rehabilitation Services (LRS) or the

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Individuals with Disabilities Education Act (IDEA) if the beneficiary meets the criteria for the programs.

Providers are required to follow the regulations and requirements as specified in this chapter, the Supports Waiver Rule (Louisiana Register, Volume 32, Number 09), the Standards for Participation Rule for home and community-based waiver providers (Louisiana Register, Volume 29 Number 09) and all applicable licensure and/or certification requirements.

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BENEFICIARY REQUIREMENTS

To qualify for the Supports Waiver (SW), a person must be 18 years of age or older, be offered a waiver opportunity slot and meet all of the following eligibility criteria:

- Meet the Developmental Disability Law criteria as defined in Appendix A;
- Have his/her name on the Developmental Disabilities Request for Services Registry (RFSR);
- Meet the financial and non-financial Medicaid eligibility criteria for Medicaid services;
- Meet the medical requirements;
- Meet the requirements for an Intermediate Care Facility for people with an Intellectual Disability (ICF/ID) level of care which requires active treatment of a developmental disability under the supervision of a qualified intellectual disabilities professional;
- Meet the determination that the SW is the OCDD waiver, based on person centered planning and a needs based assessment, that will meet the needs of the individual;
- Meet the health and welfare assurance requirements for home and community based waiver services; and
- Be a resident of Louisiana.

To remain eligible for waiver services, a beneficiary must receive one or more waiver services every thirty days.

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Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Individuals who request waiver services are placed on a statewide Developmental Disabilities Request for Services Registry (RFSR) and are selected for an OCDD waiver opportunity based on the urgency of need and earliest registry date.

Requests for waiver services must be made from the applicant or his/her authorized representative by contacting the applicant's Human Services Authority or District.

Once it has been determined by the 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 and the applicant/authorized representative will be sent a letter stating the individual's name has been secured on the RFSR along with the original request (protected) date. The individual will then undergo a screening for urgency of need. Entry into an OCDD waiver will be offered to applicants from the RFSR by urgency of need and the earliest request for services date. If, through the needs assessment and person centered planning process it is determined that the Supports Waiver is the OCDD waiver that will meet the needs of the individual, then the individual will be given a Supports Waiver slot.

Verifying Screening for Urgency of Need (SUN) and Request Date

Applicants or their authorized representatives may verify their screening for urgency of need (SUN) score and request date by calling their local Human Services Authority or District (see Appendix C).

Level of Care

The SW program is an alternative to institutional care. All waiver applicants must meet the definition of a person with developmental intellectual disability (ID) as defined in Appendix A. The LGE will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD).

The BHSF "Request for Medical Eligibility Determination" 90-L Form is the instrument used to determine if an applicant meets the level of care of an ICF/ID. The 90-L Form must be completed, signed, and dated by the individual's Louisiana licensed primary care physician. A licensed advanced nurse practitioner, or a licensed physician's assistant may sign the 90-L, but the supervising or collaborating physician's name and address must be listed. The 90-L Form must be submitted with the individual's initial or annual Plan of Care (POC) to the LGE. The LGE is responsible for determining that the required level of care is met for each beneficiary.

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The applicants/authorized representatives are ultimately responsible for obtaining the completed 90-L Form from the applicant's primary care physician. This form must be obtained prior to linkage to a support coordination agency for an initial POC and no more than 90 days before the annual POC start date.

Beneficiary Discharge Criteria

Beneficiaries will be discharged from the SW if one of the following criteria is met:

- Loss of Medicaid eligibility as determined by the parish Medicaid Office.
- Loss of eligibility for an ICF/ID level of care as determined by the LGE.
- Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities.
- Change of residence to another state with the intent of becoming a resident of that state.
- Admission to an ICF/ID facility or nursing facility with the intent to not return to waiver services. The waiver beneficiary 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 beneficiary will be discharged from the waiver on the 91st day if the beneficiary is still in the ICF/ID facility. Payment for SW services will not be authorized while the beneficiary is in an ICF/ID facility or nursing facility.
- Determination by the LGE that the beneficiary's health and welfare cannot be assured in the community through the provision of reasonable amounts of waiver services, i.e. the beneficiary presents a danger to himself or others.
- Failure to cooperate in any eligibility determination process, the initial or annual implementation of the approved POC, or the responsibilities of the SW beneficiary.
- Continuity of stay is interrupted as a result of the beneficiary not receiving SW services during a period of 30 or more consecutive days. Continuity of stay will not apply to interruptions in waiver services because of hospitalization or institutionalization (such as admission to an ICF/ID or nursing facility) as long as there is documented expectation from the treating licensed physician that the

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beneficiary will return to waiver services no later than 90 days from admission to the hospital or institution.

In the case of an event or effect that cannot be reasonably anticipated or controlled (Force Majeure), support coordination agencies, service providers, and beneficiaries, whenever possible, will be informed in writing, and/or by phone, and/or via the Medicaid website of interim guidelines and timelines for retention of waiver opportunities and/or temporary suspension of continuity of stay.

The service provider is required to notify the support coordination agency within 24 hours if the beneficiary has met any of the above stated discharge criteria.

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SECTION 43.2: RIGHTS AND RESPONSIBILITIES

RIGHTS AND RESPONSIBILITIES

Beneficiaries of Supports Waiver (SW) 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 beneficiaries to exercise their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid and to adhere to the following policies regarding beneficiary rights.

Freedom of Choice

Applicants/beneficiaries who qualify for an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) level of care, have the freedom to select institutional or community-based services. Applicants/beneficiaries 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 Louisiana Department of Health(LDH)) - Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the SW program. In order to maintain eligibility, beneficiaries have the responsibility to inform BHSF of changes in their income, address, and living situation.

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

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Participation in Care

Support coordinators and service providers shall ensure that beneficiaries/authorized representatives 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 beneficiary’s unmet needs. By taking an active part in planning his/her services, the beneficiary is better able to utilize the available supports and services.

In order for providers to offer the level of service necessary to ensure the beneficiary’s health, welfare, and support needs are met, the beneficiary must report any change in his/her service needs or interests 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 beneficiary.

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, beneficiaries have the opportunity to change support coordination providers, if one is available. Beneficiaries may request a change by contacting the local Human Services Authority or District hereafter referred to as the local governing entity (LGE).

Support coordinators will provide beneficiaries with their choice of direct service providers and help arrange for the services included in the POC. Beneficiaries have the opportunity to choose service providers initially and once every service authorization quarter (three months) unless a change is requested for good cause.

Voluntary Participation

Providers must assure that the beneficiary’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 beneficiary’s needs and outcomes. Beneficiaries 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 beneficiary will not be required to receive services that he/she may be eligible for but does not wish to receive. The intent of the SW program is to provide community-based services to individuals who would otherwise require institutionalization.

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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. Beneficiaries 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 beneficiaries 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 beneficiary shall follow the complaint reporting procedure and cooperate in the investigation and resolution of the complaint. Beneficiaries 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 beneficiaries may grieve the supports or services they receive. The support coordinator shall advise beneficiaries of this right and of their rights to appeal any denial or exclusion from the program or failure to recognize a beneficiary'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 beneficiary has a responsibility to bring problems to the attention of providers or the Medicaid program and to participate in the grievance or appeal process.

Additional Rights

Beneficiaries have the right to control their personal resources, engage in community life and receive services in the community to the same degree of access as individuals not receiving

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home and community based services, including employment. Individuals have a choice regarding services and supports, and who provides them.

Additional rights include but are not limited to the following:

- Freedom and support to control their own schedule and activities;
- Access to food at any time, unless contraindicated due to health and safety and documented in the plan of care;
- Freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
- Visitors of their choosing at any time;
- Setting must be physically accessible to the individual; and
- Control of personal resources, including wages earned from employment.

Rights and Responsibilities Form

For a complete list of the beneficiary’s rights and responsibilities, refer to Appendix D. The support coordinator must review these rights and responsibilities with the beneficiary and his/her authorized representative as part of the initial intake process into waiver services and annually thereafter.

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SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for an Office of Citizens with Developmental Disabilities waiver opportunity or an existing opportunity is vacated and funded, the next individual on the Request for Services Registry (RFSR) with the highest urgency of need screening score will receive a written notice indicating that a waiver opportunity is available. That individual will receive a needs based assessment and participate in a person centered planning process. At the conclusion of that process, if it is determined that the Supports Waiver (SW) is the most appropriate waiver for this individual, a SW offer will be extended.

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.

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 and the availability of services as well as the assistance provided through the support coordination service.

Once it has been determined that another OCDD waiver will not meet the needs of the applicant, and the Supports Waiver is the most appropriate waiver, another 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 quantity of services (including waiver and all other services) necessary to maintain the applicant safely in the community;
- The individual cost of each waiver service, and;
- The total cost of waiver services covered by the POC.

Provider Selection

The support coordinator must present the beneficiary 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 beneficiary or responsible representative complete the provider Freedom of Choice (FOC) form initially and annually thereafter for each identified waiver service.

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Initial Plan of Care

The support coordinator is responsible for:

- Notify the provider that the beneficiary has selected their agency to provide the necessary service;
- Schedule a meeting with the provider and the beneficiary to discuss services needed by the beneficiary;
- After the meeting, forward a copy of the draft POC and request the provider sign and return the following:
 - Budget Pages; and
 - Required POC provider attachments as indicated in the POC
- Forward the initial POC packet to the local Human Services Authority or District hereafter referred to as the local governing entity (LGE) for review and approval.

Annual Plan of Care

Annual POCs follow the same process as the initial POC except for the following:

- Support Coordinator Supervisors are allowed to approve an annual POC based on OCDD policy; and
- A copy of any POC approved by the Support Coordinator Supervisor and supporting documentation will be forwarded to the LGE office.

NOTE: The authorization to provide service is contingent upon approval by the LGE office or Support Coordination Supervisor.

Prior Authorization

Prior authorization (PA) is the process to approve specific services prior to service delivery and reimbursement for an enrolled Medicaid beneficiary by an enrolled Medicaid provider. The purpose of PA is to validate the service requested as medically necessary and meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon passing all the edits contained within the claims payment process, the beneficiary's continued

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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 beneficiary, provider, service code, established quantity of units, and for specific dates of service. PAs 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 and any subsequent revision, which means that only the service codes and units specified in the approved POC will be considered for PA. Services provided without prior authorization are not eligible for reimbursement.

The service provider is responsible for the following activities:

- Checking PAs to ensure all PAs for services match the approved services in the beneficiary's approved POC. Any mistakes must be immediately corrected to match the approved services in the POC.
- Verifying the direct service worker's timesheet or electronic clock in/out is completed correctly and services were delivered according to the beneficiary's approved POC before billing for the service.
- Verifying that services were documented as evidenced by timesheets or electronic clock in/out and progress notes and are within the approved service limits as identified in the beneficiary's POC.
- Verifying service data in the direct service provider, Electronic Visit Verification (EVV) system or LaSRS depending on the service and modifying the data, if needed, based on actual service delivery.
- Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system.
 - It is the provider's responsibility to ensure that billing information for the dates of service, procedure codes, and number of units delivered is correct and matches the information in LaSRS. Inconsistencies between LaSRS and provider's billing system may result in recoupment.
- Billing only for the services that were approved in the beneficiary's POC and delivered to the beneficiary.
- Reconciling all remittance advices issued by the LDH fiscal intermediary (FI) with each payment.

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- Checking billing records to ensure 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 approved due to special circumstances by the OCDD Waiver Director/designee.

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(s) of service. Once post authorization is granted, the service provider may bill the LDH FI for the appropriate unit(s) of service. Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

Changing Direct Service Providers

Beneficiaries/families may change direct service providers once every service authorization quarter (three months) with the effective date being the beginning of the following quarter. All requests for changes in services and/or service hours must be made by the beneficiary/family through the Support Coordinator.

Direct service providers may be changed for good cause at any time as approved by the LGE.

Good cause is defined as:

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

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The beneficiaries/families must contact their support coordinator to change direct service providers. The support coordinator will assist in facilitating a team meeting involving the current direct service provider(s) if agreed to by the beneficiary/family.

This meeting will address the reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider will have the opportunity to submit a corrective action plan with specific time lines, not to exceed 30 days to attempt to meet the needs of the beneficiary.

If the beneficiary/family refuses a team meeting, the support coordinator and the LGE determines that a meeting is not possible or appropriate, or the corrective action plan and timelines are not met, the support coordinator will:

- Provide the beneficiary/family with the current FOC list of service providers in his/her region;
- Assist the beneficiary/family in completing the FOC and release of information form;
- Ensure the current provider is notified immediately upon knowledge of the request and prior to the transfer;
- Obtain the case record from the releasing provider which must include:
 - Progress notes from the last six months, or if the beneficiary has received services from the provider for less than six months, all progress notes from date of admission;
 - Written documentation of services provided, including monthly and quarterly progress summaries;
 - Current POC;
 - Records tracking beneficiary's progress towards POC goals and objectives,
 - Behavior management plans, current and past if applicable;
 - Documentation of the amount of authorized services remaining in the POC, including applicable time sheets; and
 - Documentation of exit interview.

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The support coordinator will forward copies of the following to the new service provider:

- Most current POC;
- Current assessments on which 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 supports and services.

NOTE: Transfers must be made at least seven days prior to the end of the service authorization quarter. The start date should be effective the first day of the new quarter in order to coordinate services and billing. The LGE may waive this requirement in writing due to good cause, at which time the start date will be the first day of the first full calendar month.

The new service provider must bear the cost of copying, which cannot exceed the community’s competitive copying rate. If the existing provider charges a rate that exceeds the competitive copying rate, then the provider should contact the Support Coordinator to resolve the issue.

Prior Authorization for New Service Providers

The support coordinator will complete the POC revision form with the start date for the new provider and the end date for the transferring provider and submit the revision request to the LGE for approval.

Upon approval, a new PA number will be issued to the new provider with the effective starting date agreed upon. The transferring agency’s PA number will expire on the date immediately preceding the PA date for the new provider. New providers who provide services prior to the start date on the new PA will not be reimbursed.

Exceptions to the existing service provider end date and the new service provider begin date may be approved by the LGE when the reason for the change is due to good cause.

Changing Support Coordination Agencies

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A beneficiary may change support coordination agencies after a six month period or at any time for good cause if the new agency has not met their maximum number of beneficiaries. Thereafter, a beneficiary may request a change in support coordination agencies every 12 months. Good cause is defined as:

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

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

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SECTION 43.4: COVERED SERVICES**PAGE(S) 37**

COVERED SERVICES

Support Waiver services are designed to enhance the beneficiary's independence through involvement with employment and other community activities. All services must be based on need documented in the approved plan of care (POC), and provided within the state of Louisiana. The services that are available include:

- Supported employment;
- Day habilitation;
- Prevocational;
- Respite;
- Habilitation;
- Housing stabilization transition;
- Housing transition;
- Support coordination; and
- The Personal Emergency Response System (PERS).

The services are described in detail below.

Supported Employment

Supported employment (SE) are services that are designed to support a beneficiary in community-based employment, who because of their disability, require ongoing support and extended follow-along to obtain and maintain a job in an integrated competitive work setting, including:

- Customized employment or self-employment;
- Where the person is compensated at or above the minimum wage but not less than the customary wage; and
- Level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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Supported employment services significantly expand available options for a beneficiary who requires services to achieve and maintain integrated, competitive employment in the community. These services include ongoing support and follow-along services, either through paid services, unpaid natural supports such as co-workers, family, friends, and/or other comparable services as appropriate.

Beneficiaries who have the most significant disabilities may require long-term employment supports to successfully maintain a job due to the ongoing nature of the waiver beneficiary's support needs, changes in life situations or evolving and changing job responsibilities and where natural supports would not meet this need.

Competitive employment is defined as work performed on a full time or part time basis in an integrated setting which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by an employer for the same or similar work performed by individuals without disabilities.

Integrated work setting is defined as job sites in the community where most employees do not have a disability and individuals with significant disabilities interact on a regular basis with individuals without disabilities in performing their job duties.

On-going supports and follow-along are services that are needed to support or maintain a beneficiary with a disability in employment based upon the needs of the beneficiary and continue indefinitely.

Supported employment services may be utilized to:

- Support an individual in an employment opportunity in the community;
- Support an individual in establishing and/or maintaining self-employment, including home based self-employment; and
- Support a group of no more than eight beneficiaries in an employment opportunity in the community.

Supported employment services are:

- NOT meant to support a beneficiary in a volunteer job. This should be completed under prevocational services or day habilitation services; and
- Do NOT include facility-based employment furnished in specialized facilities that are not a part of the general work place and do NOT include people who do not have a disability.

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These services are divided into two categories:

- Individual employment, including Self-Employment or Microenterprise; or
 - Job assessment, discovery and development
 - Initial job support and job retention
- Group Employment.
 - Job assessment, discovery and development; and
 - Initial job support and job retention.

Job assessment, discovery and development is the process of:

- Identifying specific career interests of a beneficiary;
- Identifying appropriate community employment options that match information gained from a beneficiary's assessment, profile and/or plan;
- Ensuring the identified position will meet the occupational, physical and financial requirements of the beneficiary; and
- Assisting the beneficiary and employer in achieving a successful job match, placement, and sustaining employment.

The outcome of job assessment, discovery and development is sustained paid employment in an integrated setting in the general workforce in the community in a job that meets personal and career goals.

Job Assessment

Job assessment is the evaluation of a beneficiary's skills and interests, and consists of a combination of assessment activities:

- Vocational assessments to determine a person's career interests;
- Job analysis for each job the individual is interested in obtaining;
- Community-based situational assessments;
- Facility-based situational assessments;
- Placement plan;
- Assisting with personal care in activities of daily living; and
- Ongoing career planning.

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Examples of Career Planning activities include, but are not limited to, the following:

- On-going Career Counseling;
 - On-going discussions should be conducted with the beneficiary to help answer their questions and/or to assist them in any aspect of defining a career goal.
 - Benefits Planning;Benefit planning should be completed by a certified work incentive coordinator to assist the beneficiary in answering questions regarding Social Security benefits and working.
- Financial Literacy;
 - Financial literacy is intended to assist the beneficiary in gaining skills and knowledge in the area of their personal finances which will help them in making more cost-conscious decisions.
- Assistive Technology (AT) assessments; and
 - These assessments are conducted as needed to enhance a beneficiary's employability.
- Other activities that may assist the beneficiary in increasing their knowledge in areas that enhance their decision-making to obtain an employment goal and career path.

Job assessment will not be authorized for services that include teaching concepts such as compliance, attendance, task completion, problem-solving and safety that are associated with performing compensated work, as well as, activities aimed at a generalized outcome.

Note: These activities should be completed under prevocational services.

Documentation Requirements

To receive post-authorization for job assessment, one or more of the following documents must be submitted to the beneficiary's support coordinator for approval:

- Completed vocational assessment;
- Completed job analysis;
- Notes from community-based/ situational assessments;
- Placement plan;

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- Career planning activities documentation;
- Assistive technology (AT) assessments;
- Benefits planning documentation;
- Documentation of job internship;
- Documentation of job shadowing experience; and
- Additional documentation that substantiates other assessment activity.

Approval of job assessment documents submitted will be based on the following information:

- The objectives and time lines outlined in the Individualized Service Plan (ISP) were met timely;
- the written assessment that includes, at a minimum, the following information The identification of:
 - Specific career interest(s); Assets and abilities regarding employment;
 - Potential targeted job tasks;
 - Job conditions;
 - Anticipated support needs;
 - Potential employers;
 - Maximum hours per week and times of day the beneficiary will consider working;
 - Minimum rate of pay the beneficiary will accept;
 - Benefits that might impact the beneficiary's earnings, in particular Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) benefits;
 - Areas of town, city or parish(s) the beneficiary will consider working;
 - Transportation options and selection;
 - Identification of current work strengths/skills of the beneficiary to achieve their job choice; Identification of current barriers to the beneficiary job choice; and
 - Identification of the anticipated support needs for the beneficiary.

Job Discovery and Development

Job discovery and development consists of one or more of the following activities:

- Marketing agency services to employers that match the beneficiary's interest in order to establish business relationships that could result in job opportunities for the beneficiary;

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- Assisting the beneficiary to make use of all available job services through one-stop career centers;
- Contacting specific employers whose business matches the beneficiary's career interests, or who are advertising for open positions through newspaper advertisements, websites, or word of mouth;
- Assisting the beneficiary in creating a resume;
- Assisting the beneficiary in preparing for a job interview;
- Transporting the beneficiary to a job interview;
- Accompanying the beneficiary to a job interview, if requested;
- Referring beneficiary to work incentives, planning and assistance representatives when necessary, or as requested;
- Reconfiguring an existing position to fit the employer and beneficiary's needs, also known as job restructuring;
- Consulting and/or negotiating as needed and/or requested with employer on rate of pay, benefits, and employment contracts;
- Restructuring a work site to maximize a beneficiary's ability to perform the job, also known as job accommodations;
- Training to enable a beneficiary to independently travel from his/her home to place of employment;
- Providing employee education and training as requested by employer on disability issues;
- Providing employers with information on benefits available when hiring a person with a developmental disability such as on the job training (OJT) or Work Opportunities Tax Credit (WOTC);
- Assisting with personal care activities of daily living; and
- Planning ongoing career activities.

The following activities, in addition to the activities listed above may be included for self-employment/microenterprise:

- Coordinating access to grants and other resources needed to begin and/or sustain the enterprise;
- Identifying equipment and supplies needed;
- Facilitating consultation with groups able to offer guidance such as Louisiana Economic Development and the Small Business Administration;
- Assisting with creation of a business plan;
- Facilitating interactions with required legal entities such as necessary business licensing agencies, fire marshals and building inspectors; and
- Assisting with hiring, training and retaining appropriate employees.

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NOTE: Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

Documentation Requirements

The following documentation reflecting the beneficiary's choice of occupation as documented on the ISP must be submitted to the beneficiary's support coordinator for approval. **These elements can be listed or contained in a narrative report:**

- All objectives and timelines related to job discovery and development outlined in the ISP were met timely. If changes were made, the revised ISP and new signature page with dates must be attached;
- Dates, times, names and addresses of companies contacted and method of contact (e.g. in-person, by phone, letter, e-mail or through employer's website);
- Job restructuring activities, including meetings specific to an identified position in a community business including date, time, and names and job titles of community business staff in attendance. If meeting(s) occurred, meeting minutes must be submitted;
- Community business education and/or trainings specific to an identified job in a community business, including date, time, names and job titles of community business staff in attendance, and content of education and/or training session(s);
- Job accommodation, travel training, and any other employment related activities specific to an identified job in a community business;
- Amount of time spent in discovery and development per day; Confidentiality release forms in the beneficiary's native language, if applicable, that he/she approved contacts, meetings, education or training to occur in his/her absence; and
- Other documentation related to job discovery and development activities.

The beneficiary may **or** may not be present during the job discovery and development activities. If the beneficiary is not present, a signed and dated confidentiality release form must be completed.

Staffing Ratios for Job Assessment, Discovery and Development

Job Assessment

The beneficiary **must be** present in order to receive individual, self-employment/microenterprise or group employment job assessment services. Individual or self-employment/microenterprise job assessments must be conducted on a one staff to one beneficiary ratio. For group employment, rates for job assessment are paid per beneficiary, **not** per group.

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Job Discovery and Development

Individual and group employment job discovery and development may be billed on a one staff to multiple beneficiary ratio. The staff ratio needed to support the beneficiary must be documented on the plan of care (POC).

When individual job discovery and development is billed on one staff to multiple beneficiary ratios, post authorization documentation must show individual outcomes. For example, if an employer bills for two beneficiaries on the same day for the same time period, post authorization documentation must show that job development efforts were made for each individual according to his/her identified specific career interests.

Scenario: If more than one beneficiary's identified career interest is childcare then billing could reflect a visit to one childcare facility on behalf of both beneficiaries. However, if a beneficiary's identified career interest is childcare and the other beneficiary wishes to work in a medical setting, documentation must show visits to the specific type of business for each beneficiary.

Service Limits for Individual Job Assessment, Discovery and Development

Activities will be authorized for a maximum of **2880** standard units **in a service** year for individual job assessment, discovery and development.,

A standard unit of service is 15 minutes (1/4 hour) in job assessment, discovery, and development.

Utilization of job assessment units will be counted towards the total available units for job assessment, discovery and development for a service year. Therefore, if 2880 standard units are utilized in a service year, job discovery and development could not begin until the next service year. If all available units in job assessment, discovery and development are used only for job assessment for a beneficiary in one service year, only job discovery and development activities and not job assessment will be authorized for the next service year.

Reimbursement Requirements

Beginning September 1, 2016, the use of the Electronic Visit Verification (EVV) system is mandatory for all Supported Employment Services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS).

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Authorization of Services

To receive prior-authorization for Job Assessment, Discovery and Development services, the portion of the ISP covering these services must be submitted to the beneficiary's support coordinator with measurable goals, objectives and time lines that address these services. The ISP must be signed and dated by the beneficiary, his/her responsible representatives and the support team members indicating agreement with the goals, objectives and timelines. **The Job Assessment, Job Discovery, Job Development form must be completed** (see Appendix D).

Specific documentation that shows evidence that the goals, objectives and time lines on the ISP related to those activities have been met must be submitted to the beneficiary's support coordinator for post-authorization. If an objective or time line cannot be met timely, the provider must facilitate changes prior to the end date of the objectives and timelines on the ISP and obtain team members' dated signatures indicating agreement with the changes. Partial completion of job assessment, discovery and/or development of ISP objectives and timelines will **not** qualify for post authorization and payment.

Service Limits for Group Job Assessment, Discovery and Development

Activities will be authorized for a maximum of 480 standard units in a service year for group job assessment, discovery and development.

A standard unit of service is 15 minutes (1/4 hour) in job assessment, discovery, and development.

Utilization of job assessment units will be counted towards the total available units for job assessment, discovery and development for a service year. Therefore, if 480 standard units are utilized in a service year, job discovery and development could not begin until the next service year

Reimbursement Requirements

Beginning September 1, 2016, the use of the Electronic Visit Verification (EVV) system is mandatory for all supported employment services. The EVV system requires the electronic check in/out in the LaSRS system.

Authorization of Services

To receive prior-authorization for job assessment, discovery and development services, the portion of the ISP covering these services must be submitted to the beneficiary's support coordinator with measurable goals, objectives and time lines that address these services. The ISP must be signed

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and dated by the individual, his/her responsible representatives and support team members indicating agreement with the goals, objectives and time lines. The Job Assessment, Job Discovery, Job Development form must be completed (see Appendix D).

Specific documentation that shows evidence that the goals, objectives and time lines on the ISP related to those activities have been met must be submitted to the beneficiary's support coordinator for post-authorization. If an objective or time line cannot be met timely, the provider must facilitate changes prior to the end date of the objectives and timelines on the ISP and obtain team members' dated signatures indicating agreement with the changes. Partial completion of job assessment, discovery and/or development of ISP objectives and timelines will **not** qualify for post authorization and payment.

Individual Initial Job Support, Retention, and Follow-Along

Initial job support is provided to the beneficiary on or off the job site by provider staff. It may be intensive, intermittent, short-term and/or ongoing.

Initial job support and retention consists of one or more of the following activities:

- Provision of support at a job site by provider staff that ensures the beneficiary can maintain and meet the expectations of the employer;
- Assisting with personal care activities of daily living in the employment setting by provider staff;
- Face-to-face support off the job site by provider staff that is necessary for the beneficiary to maintain gainful employment. Examples of this kind of contact include, but are not limited to:
 - A beneficiary needing travel re-training to the work site due to changes in transportation;
 - A beneficiary needing assistance in setting up an alarm clock system at home in order to be at work on time; The beneficiary wishing to discuss a problem that involves personal issues that could affect his/her ability to retain the job at a place other than the work site;
- The beneficiary needing assistance with completing documentation required by the employer or by an agency providing benefits that are affected by work income, such as SSI.

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- Communications with the beneficiary by telephone, e-mail or fax that is necessary for the beneficiary to maintain gainful employment.
- Meetings with the community employer without the beneficiary present are limited to five days per service year; which are counted as part of the total maximum number of standard units available. Examples of when such a meeting might occur include, but are not limited to:
 - Explanation and/or demonstration of significant change in job duties which the employer feels may require re-training for the beneficiary to remain successfully employed; or
 - Discussion of a behavioral issue that may adversely impact the beneficiary's ability to remain successfully employed.

If the beneficiary is not present at a meeting with the community employer, the provider will be expected to have the following documentation available upon request of the support coordinator, Office of Citizens with Developmental Disabilities (OCDD)/Waiver Supports and Services (WSS) or Health Standards (HSS) staff:

- Date, time, names of persons in attendance at meeting;
- Location and method of meeting (i.e. face-to-face with employer, by phone, or internet/videoconference);
- Reason for meeting without beneficiary and results of meeting;
- Written documentation through applicable confidentiality release forms in the beneficiary's native language that the beneficiary approved contacts and/or meetings to occur in his/her absence; and
- Transportation to or from a community business site by provider staff in a staff or provider-owned vehicle. However, the provider must produce documentation upon request of the support coordinator or OCDD, WSS or HSS staff that all other possible sources of transportation, including those incurring a charge or without charge, have been exhausted.

NOTE: Under no circumstances can a provider charge a beneficiary, his/her responsible representative(s), family members or other support team members a separate transportation fee.

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Self-employment/microenterprise, initial job support, retention Activities and Follow-Along Activities

Initial job support is provided to the beneficiary on or off the job site by provider staff. It may be intensive, intermittent, short-term and/or ongoing. These activities can include, but are not limited to the following activities:

- Provision of support by provider staff at their job site that ensures the beneficiary can maintain and meet the expectations of the job;
- Assistance with personal care activities of daily living in the employment setting by provider staff;
- Face-to-face support off the job site by provider staff that is necessary for the beneficiary to maintain gainful employment. Examples of this kind of contact include, but are not limited to:
 - A beneficiary needing travel re-training to the work site due to changes in transportation;
 - A beneficiary needing assistance in setting up an alarm clock system at home in order to be at work on time; The beneficiary wishing to discuss a problem that involves personal issues that could affect his/her ability to retain the job at a place other than the work site;
 - The beneficiary needing assistance with completing documentation required by the job or by an agency providing benefits that are affected by work income, such as SSI; and
 - Communications with the beneficiary by telephone, e-mail or fax that is necessary for the beneficiary to maintain their employment.
- Assistance acquisition of skills necessary for operation of the business including clerical, payroll, tax functions, and inventory tracking system;
- Assistance with interviewing, hiring or terminating employees;
- Assistance with communications with vendors and customers; and
- Assistance with all functions of business operations.

Initial job support and retention will be authorized for a job a beneficiary holds in a provider-owned facility when:

- The beneficiary is paid the same wage as a regular employee of that provider, but at least minimum wage;

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- There is a job description for the position that would be utilized by the provider for a person without a disability; and
- The beneficiary is paid all benefits, including holidays, absentee and vacation time that other employees without disabilities would receive in a comparable position.

Initial job support and retention will only be authorized for individual job, self-employment/microenterprise or group employment for which the beneficiary is paid in accordance with the United States Fair Labor Standards Act of 1985 as amended.

Restrictions with Other Services

Beneficiaries receiving individualized supported employment services may also receive day habilitation or prevocational services, but these services cannot be billed for during the same service day and cannot equal more than 5 hours combined.

Staffing Ratios for Individual Initial Job Support, Retention and Follow-Along

Individual job, self-employment and microenterprise initial job support and retention must be provided with a one staff to one beneficiary ratio.

Service Limits for Individual Initial Job Support, Retention and Follow-Along:

A standard unit of service is 15 minutes (1/4 hour).

Activities will be authorized for a maximum of 960 standard units in a service year for initial job support, retention and follow-along.

Reimbursement Requirements

Beginning September 1, 2016, the use of the Electronic Visit Verification (EVV) system is mandatory for **ALL** supported employment services. The EVV system requires the electronic check in/out in the LaSRS system.

Group Employment Initial Job Support, Retention and Follow-Along

Group employment initial job support, retention and follow-along activities may be authorized in a provider-owned or leased facility when:

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- The building in which business is conducted is in a separate physical location from the rest of the provider facility; and
- Members of the public are the primary customers who utilize the services of the business.

Examples of this include, but are not limited to:

- Laundry/ironing services;
- Restaurants; and
- Retail shops.

Initial job support and retention will only be authorized for the individual job, self-employment/microenterprise or group employment for which the beneficiary is paid in accordance with the United States Fair Labor Standards Act of 1985 as amended.

Service Limits for Group Employment Initial Job Support, Retention and Follow-Along

Group employment services are provided in regular business, industry, and community settings for groups of two to eight beneficiaries with disabilities. Supported employment group services must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and individuals without disabilities in those workplaces.

The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Group employment does not include vocational services provided in facility based work settings or volunteer work.

Career planning may be included in this service as well so that beneficiaries can further plan for individual employment.

Group employment initial job support, retention and follow-along activities may be authorized for only 240 standard units in a service year. Rates are paid per beneficiary, not per group. A standard unit of service is one hour or more per day.

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Reimbursement Requirements

Beginning September 1, 2016, the use of the Electronic Visit Verification (EVV) system is mandatory for all supported employment services. The EVV system requires the electronic check in/out in the LaSRS system.

Staffing Ratios for Group Supported Employment

Group employment initial job support and retention must have one of the following staff to beneficiary ratios in order to receive payment:

- One staff to one beneficiary;
This option is only available when the staff providing the one-to-one support is in addition to a crew supervisor and is in attendance for the entire shift;
- One staff to two beneficiaries;
- One staff to three to four beneficiaries; or
- One staff to five to eight beneficiaries.

The maximum ratio for group employment is one staff to eight beneficiaries.

Restrictions with Other Services

Beneficiaries receiving group supported employment follow-along services may also receive day habilitation or prevocational services, but these services cannot be billed for on the same service day.

Additional Requirements for Supported Employment

Prior to receiving individual or group SE services, the beneficiary must apply for, and exhaust any similar services available through Louisiana Rehabilitation Services (LRS) or the Individuals with Disabilities Education Act (IDEA) if the beneficiary is still attending high school. Services will be considered unavailable if a beneficiary applies, is eligible and qualifies for LRS services but is put on a waiting list. However, if there is no waiting list, the beneficiary must utilize LRS services prior to receiving individual supported employment services through the waiver.,

There must be documentation in the beneficiary's file that supported employment services are not available from programs funded under the Rehabilitation Act of 1973, the IDEA or Medicaid State Plan.

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Place of Service

Individual Supported employment is conducted in a variety of settings, in particular at work sites in which persons without disabilities are employed. When 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 beneficiaries receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Transportation

Transportation is included in supported employment, but whenever possible, family, neighbors, friends, co-workers or community resources that can provide transportation without charge should be utilized. Under no circumstances can a provider charge a beneficiary, his/her responsible representative(s), family members or other support team members a separate transportation fee.

Provider Qualifications

Provider of individual supported employment services must meet the following requirements:

- Possess and maintain a 40-hour certificate of compliance from an LRS approved program as a community rehabilitation provider and maintain this certificate;
- Complete annual training of 16 hours of approved training
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

Providers of group supported employment services must meet the following requirements:

- Possess and maintain a 40-hour certificate of compliance from an LRS approved program as a community rehabilitation provider and maintain this certificate;
- Complete annual training of 16 hours of approved training;
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

OR

- Be licensed as an Adult Day Care provider by the Louisiana Department of Health (LDH);
- At least one vocational supervisor receives 15 hours of vocational training annually; and

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- Meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*.

Day Habilitation

Day habilitation services should focus on the person-centered planning process. Through this process, the beneficiary's likes, dislikes, interests and desires will be discovered which will assist with planning on the beneficiary's itinerary. Time should be spent exploring the community activities and experiences available to an individual in order to provide the opportunity to determine and choose how they would like to spend their time in the community.

The integration with individuals without disabilities is expected. Activities should not be created for the sole purpose of serving individuals with developmental disabilities. Beneficiaries should participate in activities already established in the community.

Day habilitation is furnished in a variety of community settings, (i.e. local recreation department, garden clubs or other clubs of interest, libraries, etc.) other than the person's residence and is not to be limited to a fixed- site facility.

Day habilitation activities should assist the individual to gain their desired community living experience, including:

- The acquisition, retention or improvement in self-help;
- Socialization and adaptive skills; and/or
- To provide the individual an opportunity to contribute to his or her community.

These activities could be educational or recreational in nature, which would include activities that are related to the beneficiary's interests, hobbies, clubs, sports, political events, etc.

Identified therapies in the beneficiary's person-centered POC may be coordinated with day habilitation services. For individuals with degenerative conditions, day habilitation may include training and supports designed to maintain skills and functioning and to slow or prevent regression rather than acquiring new skills or improving existing skills. These types of therapies should be utilized in the community at places that already offer these services to people without disabilities and not created solely for individuals with disabilities.

Career planning activities may be a component of day habilitation services where the beneficiary may explore and discover opportunities consistent with their skills and interests.

Examples of career planning activities include but are not limited to the following:

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- Self- exploration activities developed to assist the beneficiary in becoming aware of their interests, skills, and values that can help guide the career exploration/development process and allow them to think about going to work;
- Volunteering- to be done in the community in the areas identified in career exploration activities to further define a career;
- Benefits planning should be completed by a certified work incentive coordinator to assist the beneficiary in answering any questions regarding Social Security benefits and working;
- Financial literacy activities intended to assist the beneficiary in gaining skills and knowledge in the area of their personal finances which will help them in making more cost-conscious decisions and deciding that they want to go to work;
- Field trips in the community to explore places of interests that may lead to them deciding to explore work;
- Tours of businesses and meetings which provide work-based learning of career opportunities allowing beneficiaries to meet with employers to find in businesses that they may be interested in working; and
- Other activities that may assist the beneficiary in increasing his/her knowledge in areas that can assist the beneficiary in decision-making which leads to a beneficiary in deciding to go explore work.

Volunteering in the community is encouraged and should be provided under the guidelines of the United States Fair Labor Standards Act of 1985 as amended.

Beneficiaries of retirement age may also be supported in senior community activities or other meaningful retirement activities in the community, such as the local Council on Aging or other senior centers. This may also involve altering schedules to allow for more rest time throughout the day. Assistance with personal care may be a component part of day habilitation services as necessary to meet the needs of a participant, but may not comprise the entirety of the service.

Day habilitation may not provide for the payment of services that are vocational in nature – for example, the primary purpose of producing goods or performing services cannot be billed as day habilitation.

Some examples of day habilitation activities include, but are not limited to, the following:

- Participation in community inclusion activities to gain information about a specific interest;

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- Participation in a basic nutrition and/or cooking class in the community; and
- Participation in a painting class or other arts/crafts class offered in the community alongside those who do not have disabilities;
- Participation in exercise classes of their choosing offered in a local gym or community center.

Other examples of day habilitation activities include, but are not limited to, a beneficiary:

- Learning how to make proper food choices based on their nutritional needs and learns how to order from a restaurant;
- Learning basic personal safety skills or safe travel techniques;
- Volunteering in the community alongside peers without disabilities to be a part of the community and to learn the value of giving back to their community;
- A beneficiary and, as appropriate, his/her family receive information and counseling on benefits planning and assistance in the process.
- A beneficiary participates in inclusive sports activities in their community.
- A beneficiary participates in town hall meetings and other community meetings to gather a better understanding of his community.
- A beneficiary receives a basic understanding of his/her right to vote and how to vote and is given the opportunities to participate in political activities of his/her choosing in the community;
- A beneficiary receives information on current events and community events that may be of interest to him/her; and
- A beneficiary receives assistance 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. However, personal care assistance may not comprise the entirety of this service.

Place of Service

Day habilitation is furnished in a variety of community settings, (i.e. local recreation department, garden clubs or other clubs of interest, libraries, etc.) other than the person's residence and is not to be limited to a fixed- site facility.

NOTE: Volunteering cannot occur in a provider-owned business or facility and must be community oriented.

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Facility-based activities should include activities that are chosen by the beneficiary and should be integrated to the extent that the individual desires. Facility-based activities must be integrated just as community activities.

Restrictions with Other Services

Beneficiaries receiving day habilitation services may also receive prevocational or supported employment services, but these services cannot be provided during the same time period and cannot bill for more than 5 hours per day of combined vocational services.

Day habilitation services begin when the beneficiary arrives at the site where the activity will take place and the activities begin.

Staffing Ratios

Day habilitation activities may occur with one of the following staff ratios:

- One staff to one beneficiary;
- One staff to two to four beneficiaries; or
- One staff to five to eight beneficiaries.

The maximum ratio for day habilitation is one staff to eight beneficiaries.

Transportation

All transportation costs are included in the reimbursement for day habilitation services. If a beneficiary needs transportation, the provider must provide, arrange or pay for appropriate transport to and from a central location convenient for the beneficiary agreed upon by the team. The need for transportation and the location must be documented on the ISP. Beneficiaries must be present to receive this service. Under no circumstances can a provider charge a beneficiary, his/her responsible representative(s), family members or other support team members a separate transportation fee.

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Service Limits

Day habilitation must be scheduled on the service plan for one or more days per week and may be prior authorized for up to 4800 standard units of service in a POC year. A standard unit of service is 15 minutes (1/4 hour).

Reimbursement Requirements

Beginning March 1, 2016, the use of the Electronic Visit Verification (EVV) system is mandatory for day habilitation services. The EVV system requires the electronic check in/out in the LaSRS.

Authorization of Services

In order to receive prior authorization when day habilitation and habilitation services are chosen in conjunction with one another, the provider must submit specific educational strategies and timelines for each service that will be used to achieve the goals and timelines as outlined on the POC and on the ISP. This documentation must be submitted to the support coordinator within five working days after receiving the completed POC. This process must occur regardless of whether the same provider is chosen by the beneficiary for both services, or different providers are chosen for each service

The support coordinator will:

- Facilitate development of a POC that specifies but does not duplicate the training, supports and staff ratio, and time lines for Day Habilitation and Habilitation services;
- Cross reference the POC and the provider(s) ISP to ensure that no duplication of services will occur;
- Approve PA; and
- Forward the approved provider(s) ISP to the local governing entity (LGE) the same or next business day after completing the cross checks.

Provider Qualifications

Day habilitation providers must meet the following requirements:

- Be licensed as an Adult Day Care provider by the LDH;

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- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

Prevocational Services

Prevocational services are intended for those beneficiaries who want to work and have the end goal of individual integrated community employment, integrated community group employment or self-employment.

Prevocational Services are expected to last no longer than four years. Prevocational services are to be provided in a variety of locations in the community alongside individuals without disabilities. Activities are NOT to be limited to a fixed site facility. Beneficiaries receiving prevocational services may choose to pursue employment opportunities at any time and do not have to participate the entire 4 years.

Prevocational services are intended to assist the individual in developing general, non-job-task-specific strengths and skills that contribute to employability success in paid employment in integrated community settings and to assist them in developing a career path with an employment goal that is matched to the beneficiary's interests, skills, strengths, priorities, abilities and capabilities.

Prevocational services may include, but are not limited to:

- Activities to increase the beneficiary's ability to communicate effectively and appropriately when in a work environment;
- Activities to increase the beneficiary's ability to problem solve as independently as possible;
- Activities to increase their ability to be a 'team player' and understand the importance of working as part of a team in a work environment;
- Activities to assist the beneficiary in understanding the importance of having a good attitude when at work;
- Activities to assist the beneficiary in engaging in appropriate work conversations and activities with fellow co-workers;
- Participation in a class to increase their employability at the local technical college;
- Participation in a job readiness programs available through the local One Stop or other agencies;
- Activities to teach the beneficiary how to use general work related equipment;
- Activities to teach the beneficiary basic work-related personal safety skills;

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- Assistance and prompting in the development of personal skills needed to gain independence at work. This may include assistance with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, behavioral support needs and any medical task, which can be delegated. However, personal care assistance may not comprise the entirety of this service; and
- Any other activity that increases the beneficiary's employability.

Every beneficiary **MUST** have a Career Plan and should include activities focused on the participant becoming employed to their highest ability. All career planning activities should be focused on building a plan for a path to community employment at the highest level for each participant with an employment goal.

Examples of Career Plan activities include but are not limited to the following:

- Self- exploration activities- This is to include activities that helps the beneficiary become aware of their interests, skills, and values that can help guide the career exploration/development.
- Vocational Assessments- Assessments can be used to further develop the career goal.
- Career Exploration- Activities that helps the beneficiary learn how to identify career and life goals that are consistent with their interests, skills and values. It also involves opportunities to learn about the skills and qualities required to be successful in various career and the education and training needed to pursue the career.
- Volunteering- to be done in the community in the areas identified in career exploration activities. This will help to further define a career.
- Ongoing career counseling- on-going discussions should be had with the beneficiary to help them answer questions they may have or to assist them in any aspect of defining a career goal
- Benefits planning- should be completed by a Certified Work Incentive Coordinator to assist the beneficiary in answering any questions regarding Social Security benefits and working
- Financial literacy -is intended to assist the beneficiary in gaining skills and knowledge in the area of their personal finances which will help them in making more cost-conscious decisions
- Assistive technology (AT) assessments as needed to enhance a beneficiaries' employability
- Job shadowing- type of work based learning which allows beneficiaries to 'shadow' someone who works in a particular area of interests for a short period of time to gain a better understanding of what the duties are of a specific type of job.

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- Tours of businesses and meetings to learn about what businesses do and career opportunities- type of work-based learning which allows beneficiaries to meet with employers in specific businesses to find out more about a business that they may be interested in working.
- Internships– type of work-based learning which allows beneficiaries to secure internships (either paid or unpaid) in a business in order to learn more in depth aspects of the particular job they are interested in doing.
- Apprenticeships- Type of work-based learning which allows beneficiaries to secure apprenticeships that will help them develop skills in a particular area and further define a career goal; and
- Any other activities that may assist the beneficiary in increasing their knowledge in areas that can assist the beneficiary in making decisions which leads to an employment goal and career path

Every beneficiary **MUST** volunteer in the community. Volunteering will provide a beneficiary especially someone who has never worked, an opportunity to gain insight into being a responsible employee, provides them with valuable knowledge and experience which will allow them to add skills to their resume' as well as help them to decide the type of job they desire.

Volunteer activities are to be provided under the guidelines of the United States Fair Labor Standards Act of 1985 as amended. In the event beneficiaries are compensated, pay must be in accordance with the United States Fair Labor Standards Act of 1985 as amended. If beneficiaries are paid in excess of 50% of minimum wage, the provider must:

- Conduct productivity time studies on the beneficiaries every six months;
- Do six month formal reviews of the beneficiary's ISP to determine the appropriateness of continued prevocational services as opposed to supported employment; and
- Provide the support coordinator with documentation of both the productivity time studies and ISP reviews at the beneficiary's annual POC meeting.

The end goal of prevocational services, whether it's the beneficiary's choice to move to the next phase or the four year time limit is up, the beneficiary should have an employment goal and be prepared to enter into the next phase of the career path, the job search.

If at any point the beneficiary has decided that employment is not their end goal, the beneficiary should be referred to their support coordinator and be given the option to choose other day services, such as becoming part of a community group or day habilitation.

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Place of Service

Prevocational services are provided in a variety of locations in the community integrated alongside individuals without disabilities. Activities are NOT to be limited to a fixed site facility.

Staffing Ratios

Prevocational activities may occur with one of the following staff ratios:

- One staff to one beneficiary;
- One staff to two to four beneficiaries; or
- One staff to five to eight beneficiaries;

The maximum ratio for prevocational services is one staff to eight beneficiaries.

Transportation

All transportation costs are included in the reimbursement for Prevocational services. Transportation needed by the beneficiary must be documented on the POC. The beneficiary must be present to receive this service. If the beneficiary needs transportation, the provider must physically provide, arrange, or pay for appropriate transport to and from a central location convenient for the beneficiary agreed upon by the team. This location shall be documented in the service plan.

NOTE: Under no circumstances can a provider charge a beneficiary, his/her responsible representative(s), family members or other support team members a separate transportation fee.

Restrictions with Other Services

Beneficiaries receiving prevocational services may also receive day habilitation, individual supported employment or group employment assessment services, but these services cannot be provided during the same time period and the total of the services cannot equal more than five hours per day. Beneficiaries may receive group supported employment follow-along services, however these services cannot be on the same service day.

There must be documentation in the beneficiary's file that this service is not available from programs funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602 (16) or (17) of the Individuals with Disabilities Education Act (23 U.S.C. 1401) (16 and 71) and those covered under the State Plan.

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Service Limits

Prevocational services must be scheduled on the service plan for one or more days per week and may be prior authorized for up to 4800 standard units of service in a POC year. A standard unit of service is 15 minutes (1/4 hour). Choice of this service and staff ratio needed to support the beneficiary must be documented on the POC.

Reimbursement Requirements

Beginning March 1, 2016, the use of the Electronic Visit Verification (EVV) system is mandatory for prevocational services. The EVV system requires the electronic check in/out in the LaSRS system.

Provider Qualifications

Providers of prevocational services must meet the following requirements:

- Possess a certificate of compliance from Louisiana Rehabilitation Services as a Community Rehabilitation Provider and maintain this certificate;
 - Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services;
- OR**
- Be licensed as an Adult Day Care provider by the LDH;
 - At least one vocational supervisor receives 15 hours of vocational training annually; and
 - Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

Respite

Respite is a service provided on a short-term basis to a beneficiary unable to care for him/herself because of the absence of or need for relief of those unpaid caregivers/persons normally providing care for the beneficiary. Services may be provided in the beneficiary's home or private residence, or in a licensed respite care facility determined appropriate by the beneficiary or responsible party.

Respite services may be preplanned on the POC. However, if a beneficiary anticipates needing respite in the POC year, but does not know when this will occur; he/she and his/her responsible party should receive a FOC list of respite providers and interview these providers. In this manner, the beneficiary and his/her responsible party(ies) and the provider chosen will be familiar with each other. When a situation occurs during the POC year in which respite will be needed, a

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revision to the POC will be done by the support coordinator; and the beneficiary will be able to access the service in a timely manner.

Restrictions with Other Services

Beneficiaries receiving respite may use this service in conjunction with other SW services as long as services are not provided during the same period in a day.

Service Limits

The need for respite must be documented in the POC. Respite shall not exceed 428 standard units of service in a plan year. A standard unit of service is 15 minutes (1/4 hour).

Reimbursement Requirements

Beginning September 1, 2016, the use of the Electronic Visit Verification (EVV) system is mandatory for center-based respite. The EVV system requires the electronic check in/out in the LaSRS system.

Provider Qualifications

Respite service providers must meet the following requirements:

- Be licensed as a respite care service provider; and/or
- Licensed personal care attendant service provider by LDH; and
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

Habilitation

Habilitation services are designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and/or in community settings.

These services are educational in nature and focus on achieving a goal utilizing specific teaching strategies. Goals may cover a wide range of opportunities including but not limited to learning how to clean house, do laundry, wash dishes, grocery shop, bank, cook meals, shop for clothing

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and personal items, become involved in community recreational and leisure activities, do personal yard work, and utilize transportation to access community resources.

Habilitation services include but are not limited to the following:

- A beneficiary participates in activities in the community to enhance his/her social skills.
- A beneficiary learns how to make choices about their day. For example, going to a restaurant, making choices about what they want to order and learning to place their order.
- A beneficiary is taught to use the bus system or other public transportation sources and learns how to get about in their community including getting to their own individual job.
- A beneficiary participates in clubs or organizations which are related to their hobbies, sports or other areas of interest, such as political or civic events and learns how to be a contributing member of their community.
- A beneficiary receives assistance in learning how to maintain their home including, washing dishes, laundry, vacuuming, mopping and other household tasks.
- A beneficiary acquires skills needed to cook/prepare nutritional meals in their home.
- A beneficiary receives assistance in learning how to grocery shop in the community as well as other community activities such as going to the bank, library and other places in the community.
-
- A beneficiary receives assistance 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. However, personal care assistance may not comprise the entirety of this service.
-
- A beneficiary is taught how to observe basic personal safety skills in the community.

Habilitation services may be provided at any time of day or night on any day of the week as needed by the beneficiary to achieve a specified goal.

Beneficiaries in habilitation services are reasonably expected to independently achieve the goal(s) identified on their service plan within measurable time lines, as evidenced by information from their standardized assessment, personal outcome interviews and information from their support team members.

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Place of Service

Habilitation services are provided in the home or community with the beneficiary’s place of residence as the primary setting, and include the necessary transportation.

Staffing Ratio

Habilitation services may **only** be provided on a one staff to one beneficiary ratio.

Restrictions with Other Services

Beneficiaries receiving habilitation may use this service in conjunction with other Supports Waiver services as long as services are not provided during the same time period in a day.

Travel training to places in the community, where the beneficiary’s life activities take place, is considered a service. However, travel training to the beneficiary’s Group Supported Employment, Day Habilitation, or Prevocational sites is **not** considered a Habilitation service.

Authorization of Services

To receive PA when Day Habilitation and Habilitation services are chosen in conjunction with one another, the provider must submit specific educational strategies and time lines for each service that will be used to achieve the goals and time lines as outlined on the POC. This documentation must be submitted to the support coordinator within five working days after receiving the completed POC. This process must occur regardless of whether the same provider is chosen by the beneficiary for both services or different providers are chosen for each service.

Day habilitation ISP recreational goals, strategies and time lines should not be submitted. If the day habilitation ISP contains only recreational goals, the habilitation portion of the ISP is the only document that needs to be submitted to the support coordinator.

The support coordinator will:

- Facilitate development of a POC that specifies but does not duplicate the training, supports and staff ratio, and time lines for Day Habilitation and Habilitation services;

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- Cross reference the POC and the provider(s) ISP(s) to ensure that no duplication of services will occur;
- Approve prior authorization; and
- Forward the approved provider(s)' ISP(s) to the OCDD/WSS Regional Office the same or next business day after completing the cross checks.

Service Limits

Habilitation shall not exceed 285 standard units of service in a plan year. A standard unit of service is 15 minutes (¼ hour).

Provider Qualifications

Providers of Habilitation services shall meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services and one of the following two requirements:

- Be licensed as a respite care service provider and/or a personal care attendant service provider by the LDH;
- OR**
- Be a licensed occupational therapist in the State of Louisiana, or a licensed physical therapist in the State of Louisiana or certified through the National Council for Therapeutic recreation as a therapeutic recreational specialist and be an employee of an agency holding a personal care attendant and/or adult day care license through the LDH Health Standards Section.

Housing Stabilization Transition Services

Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

- Conducting a housing assessment that identifies the beneficiary's preferences related to housing (type and location of housing, living alone or living with someone else, accommodations needed, and other important preferences), and identifying the beneficiary's needs for support to maintain housing including:
 - Access to housing;

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- Meeting the terms of a lease;
 - Eviction prevention;
 - Budgeting for housing/living expenses;
 - Obtaining/accessing sources of income necessary for rent;
 - Home management;
 - Establishing credit; and
 - Understanding and meeting the obligations of tenancy as defined in the lease terms.
- Assisting the beneficiary to view and secure housing as needed. This may include:
 - Arranging or providing transportation;
 - Assisting in securing supporting documentation/records;
 - Assisting with the completing/submitted applications;
 - Assisting in securing deposits; and
 - Assisting with locating furnishings.
 - Developing an individualized housing support plan based upon the housing assessment that:
 - Includes short- and long term measurable goals for each issue;
 - Establishes the beneficiary’s approach to meeting the goal; and
 - Identifies where other provider(s) or services may be required to meet the goal,
 - Participating in the development of the POC and incorporating elements of the housing support plan, and
 - Exploring alternatives to housing if permanent supporting housing is unavailable to support completion of transition.

Standards

Housing stabilization transition services may be provided by permanent supportive housing agencies that are enrolled in Medicaid to provide this service, comply with LDH rules and regulations and be listed as a provider of choice on the Freedom of Choice (FOC) form.

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Service Exclusions

No more than 165 units of combined housing stabilization transition services and housing stabilization services (see definition) can be used per POC year without written approval from the OCDD State Office.

Service Limitations

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

No more than 72 units of housing stabilization services can be used per POC year without approval from the OCDD State Office.

Reimbursement

Payment will not be authorized until the local governing entity gives final POC approval.

The OCDD State Office reviews and ensures that all requirements are met. If all requirements are met, the POC is approved and the payment is authorized. The permanent supportive housing provider (PSH) is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

Housing stabilization transition services will be reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service is equal to 15 minutes (1/4 hour).

Housing Stabilization Services

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

- Conducting a housing assessment that identifies the beneficiary's preferences related to housing (type and location of housing, living alone or with someone else,

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accommodations needed, and other supportive preferences), and identifying the beneficiary's needs for support to maintain housing, including:

- Access to housing,
 - Meeting the terms of a lease,
 - Eviction prevention,
 - Budgeting for housing/living expenses,
 - Obtaining/accessing sources of income necessary for rent,
 - Home management,
 - Establishing credit, and
 - Understanding and meeting the obligations of tenancy as defined in the lease terms.
-
- Participating in the development of the Plan of Care, incorporating elements of the housing support plan.
 - Developing an individualized housing stabilization service provider plan based upon each assessment that:
 - Includes short- and long-term measurable goals for each issue,
 - Establishes the beneficiary's approach to meeting the goal, and
 - Identifies where other provider(s) or service may be required to meet the goal.
 - Providing supports and interventions according to the individualized housing support plan. If additional supports or services are identified as needed outside the scope of housing stabilization service, the needs must be communicated to the support coordinator,
 - Providing ongoing communication with the landlord or property manager regarding:
 - The beneficiary's disability,
 - Accommodations needed, and
 - Components of emergency procedures involving the landlord or property manager.

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- Updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status; and

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

Standards

Housing stabilization services may be provided by permanent supportive housing agencies that are enrolled in Medicaid to provide this service, comply with LDH rules and regulations, and are listed as a provider of choice on the Freedom of Choice (FOC) form.

Service Exclusions

No more than 165 units of combined housing stabilization transition or housing stabilization services (see definition) can be used per POC year without written approval from the OCDD State Office.

Service Limitations

This service is only available upon referral from the support coordinator. This service is not duplicative of the other waiver services including support coordination. This service is only available to persons who are residing in a state of Louisiana permanent supportive housing unit.

No more than 93 units of housing stabilization services can be used per year without written approval from the support coordinator.

Reimbursement

Payments will not be authorized until the OCDD state office gives final Plan of Care approval.

OCDD state office reviews all documents to ensure all requirements are met. If all requirements are met, the LGE approves the POC and authorizes the payment.

The PSH provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

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Housing stabilization services will be reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary. **A standard unit of service is equal to 15 minutes (1/4 hour).**

Personal Emergency Response Systems

A Personal Emergency Response System (PERS) is a rented electronic device that enables beneficiaries to secure help in an emergency.

The beneficiary 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 once the "help" button is activated. The response center is staffed by trained professionals.

Service Limits

Coverage of the PERS is limited to the rental of the electronic device. The monthly rental fee, regardless of the number of units in the household, must include the cost of maintenance and training the beneficiary on how to use the equipment.

Reimbursement will be made for a one-time installation fee for the PERS unit.

Agency Provider Type

Providers must be enrolled as a Medicaid Home and Community Based Services Waiver service provider of Personal Emergency Response System. The provider shall install and support PERS equipment in compliance with all applicable federal, state, parish and local laws and meet manufacturer's specifications, response requirements, maintenance records and beneficiary education requirements.

Support Coordination

Support Coordination is a service that will assist beneficiaries in gaining access to all of their needed support services, including medical, social, educational and other services, regardless of the funding source for the services.

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Support Coordination activities include but are not limited to the following:

- Convening the person-centered planning team comprised of the beneficiary, beneficiary's family, direct service providers, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies needed in order to meet the beneficiary's needs and preferences;
- On-going coordination and monitoring of supports and services included in the beneficiary's approved POC.
- On-going discussions with the beneficiary about employment including identifying barriers to employment and working to overcome those barriers, connecting the beneficiary to certified work incentive coordinators (CWIC) to do benefits planning, referring the beneficiary to Louisiana Rehabilitation Services (LRS) and following the case through closure with LRS, and other activities of the employment process as identified. This includes the quarterly completion of and data input using the Path to Employment Form.
- Building and implementing the supports and services as described in the POC.
- Assisting the beneficiary to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the beneficiary in the POC.
- Providing information to the beneficiary on potential community resources, including formal resources and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining his/her desired personal outcomes.
- Assisting with problem solving with the beneficiary, supports, and services providers.
- Assisting the beneficiary to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet their individual needs.
- Advocacy on behalf of the beneficiary to assist them in obtaining benefits, supports or services, i.e. to help establish, expand, maintain and strengthen the beneficiary's information and natural support networks. This may involve calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary.
- Training and supporting the beneficiary in self-advocacy, i.e. the selection of providers and utilization of community resources to achieve and maintain his/her desired outcomes.
- Oversight of the service providers to ensure that their beneficiary receives appropriate services and outcomes as designated in the POC.

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- Assisting the beneficiary to overcome obstacles, recognize potential opportunities and developing creative opportunities.
- Meeting with the beneficiary in a face-to-face meetings as well as phone contact as specified. . This includes meeting them where the services take place.
- Must report and document any incidents/complaints/abuse/neglect according to the OCDD policy.
- Must arrange any necessary professional/clinical evaluations needed and ensure beneficiary choice.
- Must identify, gather and review the array of formal assessments and other documents that are relevant to the beneficiary’s needs, interests, strengths, preferences and desired personal outcomes.
- Prepare the annual social summary.
- Develop an action plan in conjunction with the beneficiary to monitor and evaluate strategies to ensure continued progress toward the beneficiary’s personal outcomes.

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

Service Limits

Support Coordination shall not exceed 12 units. A unit is considered a month.

Provider Qualifications

Support Coordination providers must meet the following requirements:

- Be licensed as a support coordination provider; and
- Meet all requirements in the *Standards for Participation for Medicaid Home and Community-Based Waiver Services*.

NOTE: Please refer to the Case Management manual for additional information.

PROGRAM MONITORING

Services offered through Louisiana Supports Waiver are closely monitored to assure compliance with Medicaid’s policy as well as applicable state and federal regulations.

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.

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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 (see 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 authorized representative in writing **within 10 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 local governing entity (LGE) 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.

The OCDD may determine when the complaint is initiated that a disclosure statement is

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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 Central 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)
- Neglect - is the failure, by a caregiver responsible for an adult's care or by other

CHAPTER 43: SUPPORTS WAIVER

SECTION 43.6: INCIDENTS, ACCIDENTS AND COMPLAINTS

PAGE(S) 4

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 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**
- 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 criteria that later in life may be considered to be a developmental disability.

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APPENDIX B: SERVICE PROCEDURE CODES/RATES

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

HIPPA CODE NAME	SERVICE DESCRIPTION	HIPAA CODE	MODIFIER	RATE	STANDARD UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Supported Employment	Individual job self-employment or microenterprise job assessment, discovery, and development	H2023	UK	\$ 4.33	15 minutes		2880
Supported Employment	group employment job assessment, discovery, and development	H2023	NO MOD	\$ 3.63	15 minutes		480
Supported Employment	Individual job, self-employment or microenterprise initial job support, and retention	H2023	TS	\$ 13.00	15 minutes		960
Supported Employment	Group employment initial job support and Retention, one staff to one-two participant ratio	H2026	TT	\$ 77.00	1 DAY	1 plus	240
Supported Employment	Group employment initial job support and retention, one staff to one to three-four participant ratio	H2026	UQ	\$ 62.67	1 DAY	1 plus	240
Supported Employment	Group employment initial job support and retention, one staff to one to five-eight participant ratio	H2026	NO MOD	\$ 46.90	1 DAY	1 plus	240
Day Habilitation	Day habilitation, one staff to one participant	T2021	TT	\$ 4.13	15 minutes		4800
Day Habilitation	Day Habilitation One staff to two-four participant ratio	T2021	UQ	\$ 3.25	15 minutes		4800
Day Habilitation	Day habilitation, one staff to five to eight participant ratio	T2021	NO MOD	\$ 2.35	15 minutes		4800
Prevocational Habilitation	Prevocational services, one staff to one participant ration	T2025	TT	\$ 4.13	15 minutes		4800
Prevocational Habilitation	Prevocational services, one staff to two to four participant ration	T2025	UQ	\$ 2.75	15 minutes		4800
Prevocational Habilitation	Prevocational services, one staff to five to eight participant ratio	T2025	NO MOD	\$ 1.85	15 minutes		4800
Respite	Center-based respite	T1005	HQ	\$4.00	15 MINUTES		428
Attendant Care Services	In-home respite	S5125	NO MOD	\$4.00			

CHAPTER 43: SUPPORTS WAIVER

APPENDIX B: SERVICE PROCEDURE CODES/RATES

HIPPA CODE NAME	SERVICE DESCRIPTION	HIPAA CODE	MODIFIER	RATE	STANDARD UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Habilitation Supported Employment	Habilitation	T2019	NO MOD	\$4.00	15 MINUTES		285
Personal Emergency Response System	PERS installation	Z0058	NO MOD	\$30.00	One Time		1 in current residence and 1 each time participant moves to new residence
Personal Emergency Response System	PERS monthly maintenance	Z0059	NO MOD	\$28.00	Monthly		12
Case Management	Support coordination	T2023	NO MOD	\$ 155.00	Monthly		12
Permanent Supportive Housing	Housing stabilization	Z0648	NO MOD	\$15.11	15 MINUTES		93
	Housing stabilization transition	Z0649					72

CHAPTER 43: SUPPORTS WAIVER**APPENDIX C: CONTACT INFORMATION****PAGE(S) 2****CONTACT INFORMATION****Office for Citizens with Developmental Disabilities (OCDD) and Local Governing Entities**

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>.

Appeals

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Louisiana Department of Health (LDH) Health Standards Section	Office to contact to report changes that affect provider license	Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 or (225) 342-0138 Fax: (225) 342-5073
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 44033 Baton Rouge, LA 70804-4033 (225) 342-1800 Fax: (225) 342-1812
DXC Technology (formerly Molina) Provider Enrollment Section	Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer	DXC Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370
DXC Technology (formerly Molina) Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information	DXC Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or 225-924-5040

CHAPTER 43: SUPPORTS WAIVER

APPENDIX C: CONTACT INFORMATION

Department of Children and Family 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.dcfslouisiana.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 18-59 or an emancipated minor	Louisiana Department of Health Office of Aging and Adult Services 1-800-898-4910
Elderly Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a recipient age 60 or older	Governor’s Office of Elderly Affairs http://goea.louisiana.gov

FORMS AND LINKS

This section contains a list of the forms, handbooks and other documents that are used in the Supports Waiver program and the associated web links where the information can be obtained. Providers are required to follow the policy and procedures that are outlined for each of the documents utilized in the Supports Waiver.

For additional documents and forms that may be utilized in the Supports Waiver use this link: <http://www.ldh.la.gov/index.cfm/newsroom/detail/1564>

Form/Document Name	Web Address
Job Assessment, Job Discovery, and Job Development Completion Form	http://ldh.la.gov/assets/docs/OCDD/publications/OCDDWSSPF07001SWJAJDJDForm032707.pdf
Rights and Responsibilities Form	http://www.ldh.la.gov/index.cfm/newsroom/detail/1564
OCDD Critical Incident Reporting for Waiver Services	http://www.ldh.la.gov/assets/docs/OCDD/Critical-Incident-Reporting/OCDDC_HCBSCriticalIncidentReportFillableForm7.31.19.pdf
Quality Enhancement Provider Handbook	http://ldh.la.gov/assets/docs/OCDD/waiver/QEProviderHandbook080108.pdf
Universal Plan of Care document and attachments	http://www.ldh.la.gov/index.cfm/newsroom/detail/1564
Guidelines for Support Planning	http://ldh.la.gov/assets/docs/OCDD/waiver/NOW/Guidelines_Support_Planning.pdf
Bureau of Health Services Financing (BHSF) Form 90-L	http://www.ldh.la.gov/assets/docs/OCDD/waiver/NOW/90LForm0318Fillable.pdf

CLAIMS FILING

Hard copy billing of waiver services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required**, **situational** or **optional**.

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

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

Paper claims should be submitted to:

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

Services may be billed using:

- The rendering provider’s individual provider number as the billing provider number for independently practicing providers; or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a ‘group/clinic’ practice.

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

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and a sample of a completed CMS-1500 claim form; and
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

CMS 1500 (02/12) INSTRUCTIONS FOR SUPPORTS WAIVER SERVICES

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

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APPENDIX E – CLAIMS FILING

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

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

Locator #	Description	Instructions	Alerts
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabeled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

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

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APPENDIX E – CLAIMS FILING

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

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APPENDIX E – CLAIMS FILING

Locator #	Description	Instructions	Alerts
24D	Procedures, Services, or Supplies	Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	Required -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	ID Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID#	Situational – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is required . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is optional .	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax ID Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

Locator #	Description	Instructions	Alerts
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	RESERVED FOR NUCC USE	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials	Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required.	
	Date	Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabeled	Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number must appear on paper claims.

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

Sample forms are on the following pages

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

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



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA										PICA	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>	MEDICAID (Medicaid #) <input checked="" type="checkbox"/>	TRICARE (ID#DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		9876543210123		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS			3. PATIENT'S BIRTH DATE MM DD YY 07 31 72		SEX M <input checked="" type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F) b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME						
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED DATE		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 15. OTHER DATE MM DD YY QUAL 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO \$ CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Incl. 9 A. 3510 B. C. D. E. F. G. H. I. J. K. L. 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 4123123123						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. BR011 Part 1	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
1 03 31 14 03 31 14 12	S5125	UN		A	90 00	30	NPI				
2 04 02 14 04 02 14 12	S5125	UN		A	75 00	25	NPI				
3							NPI				
4							NPI				
5							NPI				
6							NPI				
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES NO		28. TOTAL CHARGE \$ 165 00		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) SIGNED Jane Doe DATE 4/5/14			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # (225) 555-4957 Here For You Waiver 200 Main St Any Town, LA 70000 a. 1239876543 b. 1239876					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)



WAIVER

HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA PICA <input type="checkbox"/>														
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> (Medicaid #)	TRICARE (ID# DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS						3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		9876543210123				
5. PATIENT'S ADDRESS (No., Street) CITY STATE				6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE								
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO c. OTHER ACCIDENT? YES NO d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.		11. INSURED'S POLICY GROUP OR FECA NUMBER		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO c. OTHER ACCIDENT? YES NO d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.	11. INSURED'S POLICY GROUP OR FECA NUMBER	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED	14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL:	15. OTHER DATE QUAL: MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 71b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES NO \$ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0 A. G5 10 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER Prior Auth#
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HPCS) MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAY'S OR UNITS	H. (FIRST) Party Pay	I. ID. QUAL.	J. RENDERING PROVIDER ID. #					
1 10 08 15 10 08 15 12			S5125 UN	A	90 00	30	NPI							
2 10 09 15 10 09 15 12			S5125 UN	A	75 00	25	NPI							
3							NPI							
4							NPI							
5							NPI							
6							NPI							
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234		27. ACCEPT ASSIGNMENT? (For gnt. claim, see back) <input checked="" type="checkbox"/> YES NO		28. TOTAL CHARGE \$ 165 00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 165 00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000								
SIGNED Ima Biller DATE 10/15/15			a.			b.			a. 123967654 b. 1239876					

EXAMPLE OF ICD 10

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ADJUSTING/VOIDING CLAIMS

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

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

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

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

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

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

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

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

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

Adjustments/Voids Appearing on the Remittance Advice

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

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

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

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

Sample forms are on the following pages.

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

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



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>	MEDICAID (Medicaid #) <input type="checkbox"/>	TRICARE (ID#DoD#) <input type="checkbox"/>	CHAMPVA (Member ID#) <input type="checkbox"/>	GROUP HEALTH PLAN (ID#) <input type="checkbox"/>	FECA BLK LUNG (ID#) <input type="checkbox"/>	OTHER (ID#) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		9876543210123		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS						3. PATIENT'S BIRTH DATE MM DD YY 07 31 72		SEX M X F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) NO YES c. OTHER ACCIDENT? YES NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M SEX F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. OTHER HEALTH BENEFIT PLAN? YES NO If yes complete items 9, 9a and 9d.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED DATE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 9						22. RESUBMISSION CODE ORIGINAL REF. NO. A 00 4094198765400					
23. PRIOR AUTHORIZATION NUMBER 4123123123						20. OUTSIDE LAB? YES NO \$ CHARGES					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS (9907) Family Plan H. ID. QUAL I. ID. QUAL J. RENDERING PROVIDER ID.#											
1 03 31 14 03 31 14 12 S5125 UN A 75 00 25 NPI											
2 NPI											
3 NPI											
4 NPI											
5 NPI											
6 NPI											
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO		28. TOTAL CHARGE \$ 75 00		29. AMOUNT PAID \$	
30. BALANCE DUE \$				31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe DATE 4/9/14				32. SERVICE FACILITY LOCATION INFORMATION a. 1239876543 b. 1239876			
33. BILLING PROVIDER INFO & PH # (225) 555-4957 Here For You Waiver 200 Main St. Any Town, LA 70000											

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CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

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



WAIVER

HEALTH INSURANCE CLAIM FORM

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

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

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CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING



HEALTH INSURANCE CLAIM FORM

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

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

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