



# **ADULT DAY HEALTH CARE WAIVER (ADHC) PROVIDER MANUAL**

*Chapter Nine of the Medicaid Services Manual*

**Issued December 1, 2010**

**State of Louisiana  
Bureau of Health Services Financing**

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## **OVERVIEW**

The Adult Day Health Care (ADHC) Waiver is a Medicaid Home and Community-Based Services Waiver providing alternative services to individuals which allows them to live in the community instead of a nursing facility or institution.

This provider manual chapter specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of federal and state laws and Department of Health and Hospitals (DHH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. Should a conflict exist between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This manual chapter is intended to provide an ADHC Waiver provider with the information necessary to fulfill its vendor contract with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and department rules.

The DHH Bureau of Health Services Financing (BHSF) and the DHH Office of Aging and Adult Services (OAAS) are responsible for assuring provider compliance with these regulations.

The BHSF's Health Standards Section issues and determines compliance with state licensing requirements for providers requiring a Case Management or ADHC license as required to provide services specified in the approved Plan of Care.

Waiver services to be provided are specified in the Plan of Care which is written by the support coordinator based on input from the planning team and then forwarded to the OAAS for approval. The planning team is comprised of the recipient, the support coordinator, and in accordance with the recipient's preferences, members of the family/natural support system, appropriate professionals and others whom the recipient chooses. The Plan of Care contains all services and activities involving the recipient, non waiver as well as waiver services. Recipients are to receive those waiver services included in the Plan of Care and approved by OAAS. Notification of approved services is forwarded to the provider by the support coordinator, and the contracted data management agency issues prior authorization to the providers based on the approved Plan of Care.

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the Centers for Medicare and Medicaid Services.

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## **COVERED SERVICES**

This section provides information about the services that are covered in the Adult Day Health Care (AHDC) Waiver program. For the purpose of this policy, whenever reference is made to “individuals”, this includes providing assistance to the individual’s personal representative(s), legal guardian(s) and/or family member(s), when applicable and appropriate as they assist the recipient to obtain these services.

### **Support Coordination**

Support coordination, also referred to as case management, is a service designed to assist recipients in gaining access to necessary waiver and State Plan services, as well as medical social, educational and other services, regardless of the funding source for these services. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the recipient’s approved Plan of Care.

#### **Standards**

Providers must be licensed by the Medicaid Health Standards Section (HSS) as a case management provider, be enrolled in Medicaid as a provider of this service and sign a performance agreement with the Department of Health and Hospitals (DHH), Office of Aging and Adult Services (OAAS). Refer to the Case Management Services manual chapter for more detailed information about this service.

### **Transition Intensive Support Coordination**

Transition intensive support coordination (TISC) assists individuals currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and Medicaid State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source.

#### **Standards**

Providers must be licensed by the Medicaid HSS as a case management provider, be enrolled in Medicaid as a provider of this service, sign a performance agreement with the DHH OAAS and be listed on the Freedom of Choice Form (FOC). Refer to the Case Management Services manual chapter for more detailed information about this service.

### **Service Exclusions**

Support coordination agencies are not allowed to bill for this service until after the individual has

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been approved for the AHDC Waiver.

The scope of TISC does not overlap with the scope of support coordination; therefore, duplicate billing is not allowed.

### **Transition Services**

Transition Services assist an individual, who has been approved for an ADHC Waiver opportunity, to leave a nursing facility and return to live in the community.

Transition Services offer assistance with time limited, non-recurring set-up expenses for individuals who have been offered and approved for an ADHC Waiver opportunity and are transitioning from a nursing facility to their own living arrangement. Allowable expenses are those necessary to enable the individual to establish a basic household. These services must be identified in the individual's approved Plan of Care.

When the individual requires services that exceed the one-time maximum limit allowed, the support coordinator identifies and refers the individual and/or responsible representative to other community resources.

Transition Services include the following:

- Security deposits that are required to obtain a lease on an apartment or house,
- Specific set-up fees or deposits for:
  - Telephone,
  - Electricity,
  - Gas,
  - Water, and
  - Other such housing start-up fees and deposits.
- Essential furnishings to establish basic living arrangements:
  - Living Room – sofa/love seat, chair, coffee table, end table, and recliner,
  - Dining Room – dining table and chairs,
  - Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers, nightstand, comforter, sheets, pillows, lamp, and telephone,
  - Kitchen – refrigerator; stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, and dishcloths, towels, potholders,



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- Bathroom – towels, hamper, shower curtain, and bath mat,
  - Miscellaneous - window coverings, window blinds, curtain rod, washer, dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron, and ironing board, and
  - Moving Expenses – moving company and cleaners (prior to move; onetime expense).
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- Health and welfare assurances
    - Pest control/eradication,
    - Fire extinguisher,
    - Smoke detector, and
    - First aid supplies/kit.

**Standards**

Providers must be licensed by the HSS as a case management provider, enrolled in Medicaid as a provider of these services, sign a performance agreement with the DHH OAAS, and be listed on the Freedom of Choice (FOC) form.

Refer to the Case Management Services manual chapter for more detailed information about this service.

**Service Exclusions**

Transition services do not include the following:

- Monthly rent payments,
- Mortgage payments,
- Food,
- Monthly utility charges, and
- Household appliances and/or items intended solely for diversionary/recreational purposes (i.e. television, stereo, computer, etc.).

These services do not constitute room and board. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

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**Service Limitations**

There is a \$1,500 one-time maximum limit per individual. Services must be prior approved by the OAAS regional office and require prior authorization (PA).

These services are available to individuals who are transitioning from a nursing facility to their own private residence where the individual is directly responsible for his/her own living expenses. When the individual transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the individual.

The purchaser for these items may be the individual, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, the support coordination agency is the only source that can bill for these services.

**Reimbursement**

Payment shall not be authorized until the OAAS regional office gives final Plan of Care approval upon receipt of the 18-W.

When the OAAS regional office issues final approval, the data management contractor is notified to set up a transition service expense record in the database for the individual and to release the PA. The support coordination agency is notified of the release of the PA and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse that actual purchaser within ten calendar days of receipt of reimbursement by the support coordination agency.

The OAAS regional office shall maintain documentation, including each individual's "OAAS Transition Services Expense and Planning Approval (TSEPA) Form" with original receipts and copies of cancelled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes.

Billing for transition services must be completed within 60 calendar days after the individual's actual move date in order for the reimbursement to be paid.

**NOTE: If the individual is not approved for ADHC Waiver services and/or does not transition, but transition service items were purchased, the OAAS regional office should notify the OAAS state office to allow for possible reimbursement.**

If it is determined that additional items are needed after the TSEPA request was approved, and there are remaining TSEPA funds in the individual's budget, the support coordinator must submit a TSEPA form within 90 calendar days after the individual's actual move date. The same procedure outlined above shall be followed for any last minute needs.

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**Adult Day Health Care Service**

ADHC services are a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. Services are furnished for five or more hours per day (exclusive of transportation time to and from the ADHC facility) on a regularly scheduled basis for one or more days per week, or as specified in the Plan of Care and ADHC individualized service plan (ISP).

An ADHC facility shall, at a minimum, furnish the following services:

- Individualized training or assistance with the activities of daily living (toileting, grooming, eating, ambulation, etc.),
- Health and nutrition counseling,
- An individualized, daily exercise program,
- An individualized, goal directed recreation program,
- Daily health education,
- Medical care management,
- One nutritionally-balanced hot meal (lunch) and two snacks served each day. If applicable, the meals/snacks shall meet the recipient's dietary needs, as ordered by his/her physician. Two hours are required between the snack and lunch, one hour for lunch, and two hours between lunch and the next snack totaling five hours. Liquids shall be available and easily accessible at all times.

**NOTE: A provider may serve breakfast in place of a mid-morning snack.**

- Nursing services that include the following individualized health services:
  - Monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly,
  - Administering medications and treatments in accordance with physicians' orders,
  - Monitoring self-administration of medications while the recipient is at the ADHC facility, and
  - Serving as a liaison between the recipient and medical resources including the treating physician.

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**NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.**

- Transportation from the recipient's place of residence to the ADHC facility. The cost of this transportation is included in the rate paid to providers of ADHC services. The recipient and his/her family may choose to transport the recipient to the ADHC facility. Transportation provided by the recipient's family is not a reimbursable service, and
- Transportation to and from medical and social activities when the recipient is accompanied by ADHC facility staff.

**NOTE: If transportation services that are prescribed in any recipient's approved ISP are not provided by the ADHC facility, the facility's reimbursement rate shall be reduced accordingly. It is allowable for an ADHC to refuse services to someone because the individual resides outside of the ADHC's established limited mileage radius for transportation to and from the center as long as this transportation policy is approved by the DHH HSS.**

**Standards**

Providers must be licensed by the HSS as an Adult Day Health Care provider, enrolled in Medicaid as an ADHC provider and must be listed on the FOC form prior to providing ADHC services.

**Service Exclusions**

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

ADHC providers will not be reimbursed for any recipient who has attended less than five hours per day.

It is permissible for a person to attend an ADHC facility outside of their region.

**Service Limitations**

These services must be provided in the chosen ADHC facility.

Reimbursement for these services requires PA.

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**Reimbursement**

Payment will not be authorized until the OAAS regional office gives final Plan of Care approval.

OAAS regional office reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved Plan of Care to the recipient and ADHC provider. The ADHC provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

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**SECTION 9.2: RECIPIENT REQUIREMENTS****PAGE(S) 2**

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**RECIPIENT REQUIREMENTS**

The Adult Day Health Care (ADHC) Waiver program is only available to individuals who meet all the following criteria:

- Medicaid financial eligibility,
- Age 65 years or older, **OR** 22 through 64 years of age with a disability that meets Medicaid standards or the Social Security Administration's disability criteria,
- Nursing facility level of care requirements,
- Name on the Request for Services Registry for the ADHC Waiver, and
- A Plan of Care sufficient to:
  - Assure the health and welfare of the waiver applicant in order to be approved for waiver participation or continued participation, and
  - Justify that the ADHC Waiver services are appropriate, cost effective and represent the least restrictive environment for the individual.

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

**Request for Services Registry**

The Department of Health and Hospitals (DHH) is responsible for the Request for Services Registry (RFSR), hereafter referred to as "the registry," for the ADHC Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll-free telephone number which is maintained by the Office of Aging and Adult Services (OAAS).

Individuals will be screened to determine whether they meet nursing facility level of care. Only individuals who meet this criterion will be added to the registry. The individual's name is placed on the registry in request date order.

ADHC Waiver opportunities are offered based on the date of first request for services, with priority given to individuals who are in a nursing facility, but could return to their home if ADHC Waiver services are provided.

If an applicant is determined to be ineligible for any reason at the time an offer is made, the next individual on the registry based on the above stated priority group is notified and the process

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continues until an individual is determined eligible. An ADHC Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

**Admission Denial or Discharge Criteria**

Failure of the individual to cooperate in the eligibility determination process or to meet any of the following criteria will result in denial of admission to/discharge from the ADHC waiver:

- The individual does not meet the criteria for Medicaid financial eligibility,
- The individual does not meet the criteria for a nursing facility level of care,
- The recipient resides in another state or has a change of residence to another state,
- Continuity of services is interrupted as a result of the recipient not receiving and/or refusing ADHC waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

**Note: Continuity of services will not apply when interruptions are due to a recipient being admitted to a rehabilitation hospital or nursing facility so long as the stay does not exceed 90 consecutive days.**

- The health and welfare of the individual cannot be reasonably assured through the provision of the ADHC waiver services within the individual's cost effectiveness,
- The individual fails to cooperate in the eligibility determination process or in the performance of the Plan of Care, or
- It is not cost effective to serve the individual in the ADHC waiver.

Involuntary discharge/transfer from the waiver may occur for one of the following:

- Medical protection or the well being of the individual or others,
- Emergency situation (i.e., fire or weather related damage),
- Health or welfare of the recipient is threatened, or
- An inability of the ADHC provider to furnish the services indicated in the recipient's Plan of Care after documented reasonable accommodations have failed.

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**SECTION 9.3: RECIPIENT RIGHTS/RESPONSIBILITIES** **PAGE(S) 3**

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**RECIPIENT RIGHTS AND RESPONSIBILITIES**

Recipients have specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs. Support coordinators and service providers must assist recipients to exercise their rights and responsibilities. Every effort must be made to assure that applicants or recipients understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid to adhere to the following policies on recipient rights.

**Freedom of Choice of Program**

Individuals who have been offered waiver services have the freedom to select between the institutional care services and community-based services. They have the responsibility to participate in the evaluation process which 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. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

**Freedom of Choice of Support Coordination and Service Providers**

At the time of admission to the waiver, and every six months thereafter, recipients have the opportunity to change support coordination providers, if one is available. A recipient may change support coordination agencies at any time with good cause.

Recipients also have the freedom of choice to select their Adult Day Health Care (ADHC) provider. Recipients may change their ADHC provider once every six months or at any time with good cause. Support coordinators will provide recipients their choice of ADHC providers and help arrange and coordinate the services on the Plan of Care.

**Adequacy of Care**

All recipients in Louisiana's home and community-based waiver programs have the right to choose and receive the services necessary to support them to live in a community setting. Services are arranged and coordinated through the support coordination system and approval by the Office of Aging and Adult Services (OAAS) regional office staff. Administrative limits are placed on some services according to the waiver that is authorized by the Center for Medicare and Medicaid Services.

Recipients have the responsibility to request only those services they need and not request excess services, or services for the convenience of providers or support coordinators. Units of service are not "saved up". The services are certified as medically necessary and are revised on the Plan



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of Care as each recipient's needs change.

**Participation in Care**

Each recipient shall participate in a person-centered planning meeting and any other meeting involving decisions about services and supports to be provided as part of the waiver process. Person-centered planning will be utilized in developing all services and supports to meet the recipient's needs. By taking an active part in planning his/her services, the recipient is better able to utilize the available supports and services. The recipient shall report any service need change to his/her support coordinator and service provider(s).

Changes in the amount of services must be requested by the support coordinator at least 15 days before taking effect, except in emergencies. These changes must be approved by the OAAS regional office. Providers may not initiate requests for change of service or modify the Plan of Care without the participation and consent of the recipient.

**Voluntary Participation**

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

**Quality of Care**

Each recipient of home and community-based waiver services has the right to receive services from provider agency employees who have been trained and are qualified to provide them. In cases where services are not delivered according to the approved Plan of Care or there is abuse or neglect on the part of the service provider, the recipient shall follow the complaint reporting procedure and cooperate in the investigation and resolution of the complaint. Recipients may not request providers to perform tasks that are illegal or inappropriate, and they may not violate the rights of other recipients.

**Civil Rights**

Providers shall operate in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. This means that individuals are accepted and that all services and facilities are available to persons

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without regard to race, color, religion, age, sex, or national origin. Recipients have the responsibility to cooperate with their providers by not requesting services which in any way violate these laws.

**Notification of Changes**

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

The OAAS is responsible for approving level of care and medical certification. In order to maintain this certification, recipients have the responsibility to inform the OAAS, through their support coordinator, of any significant changes which affects their service needs. Neither support coordinators nor service providers may approve or deny eligibility for the waiver.

**Grievances/Fair Hearings**

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

Each support coordination/direct service provider shall have grievance procedures through which recipients may grieve the supports or services they receive. The provider shall advise recipients of this right and of their rights to a fair hearing and the process for an appeal 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, if requested.

An appeal by the recipient may be filed at the local Medicaid Office or with the Department of Health and Hospitals' Bureau of Appeals. (See Appendix A for contact information)

**Complaint/Help Lines**

Toll-free numbers are available to provide waiver assistance, clarification of waiver services, and reporting complaints regarding waiver services including reports of abuse, neglect and exploitation. (See Appendix A for contact information)

These toll-free numbers are accessible within the State of Louisiana.

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**SECTION 9.4: SERVICE ACCESS AND AUTHORIZATION** **PAGE(S) 7**

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**SERVICE ACCESS AND AUTHORIZATION**

When funding is appropriated for a new Adult Day Health Care (ADHC) Waiver opportunity or an existing opportunity is vacated, the individual who meets criteria for the priority group, or whose date is reached on the Request for Services Registry (RFSR) shall receive a written notice indicating that a waiver opportunity is available. The applicant will receive a waiver offer packet that includes a Waiver Decision Form and a Support Coordination Agency Freedom of Choice form.

The applicant must complete and return the packet to indicate interest in receiving an ADHC Waiver opportunity and to determine if he/she meets the level of care and/or additional targeting criteria.

If the applicant meets the level of care and/or targeting criteria, he/she will be linked to a support coordination agency. A support coordinator will be assigned to conduct an in-home assessment with the applicant and inform him/her of all available services.

Once it has been determined that the applicant meets the level of care requirements for the program, a second home visit is made to finalize the Plan of Care. The following must be addressed in the Plan of Care:

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

**Provider Selection**

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

The support coordinator is responsible for:

- Notifying the provider that the recipient has selected their agency to provide the necessary service,

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- Forwarding the Plan of Care packet to the Office of Aging and Adult Services (OAAS) regional office for review and approval following the established protocol.

**NOTE: The authorization to provide service is contingent upon approval by the OAAS regional office.**

**Prior Authorization**

All services under the ADHC Waiver must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid recipient by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all edits contained within the claims payment process, the recipient's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a recipient, provider, service code, established quantity of units, and for specific dates of service.

PA revolves around the Plan of Care document, which means that only the service codes and units specified in the approved Plan of Care will be prior authorized. Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The service provider is responsible for the following activities:

- Developing an Individual Service Plan (ISP) in accordance with the approved Plan of Care.
- Checking prior authorizations to verify that all prior authorizations for services match the approved services in the recipient's Plan of Care. Any mistakes must be immediately corrected to match the approved services in the Plan of Care.
- Verifying that the case record documentation is completed correctly and that services were delivered according to the recipient's approved Plan of Care prior to billing for the service.
- Verifying that services were documented as evidenced by timesheets, attendance records, progress notes and progress summaries and are within the approved service limits as identified in the recipient's Plan of Care prior to billing for the service.

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- Completing data entry into the direct service provider data system, Louisiana Services Tracking (LAST) system.
- Inputting the correct date(s) of service, authorization numbers, provider number, and recipient number in the billing system.
- Billing only for the services that were delivered to the recipient and are approved in the recipient's Plan of Care.
- Reconciling all remittance advices issued by the Department of Health and Hospitals (DHH) fiscal intermediary with each payment.
- Checking billing records to ensure that the appropriate payment was received.

**NOTE:** Service providers have one-year timely filing billing requirement under Medicaid regulations.

Support coordination services are assigned a PA number for a six month period with one unit assigned per month.

Transition Intensive Support Coordination is authorized upon receipt of the Plan of Care and the "Request for Payment/Override Form" that have been approved by the OAAS regional office. (See Appendix B for a copy of this form)

Transition services are issued PA with the effective date of the Plan of Care or a revision request through the Plan of Care end date. The initial PA is mailed to the support coordination agency. The OAAS regional office forwards the "OAAS Transition Services Expense and Planning Approval (TSEPA) Form" to the data contractor for release of payment after receiving the required information from the local Medicaid office. (See Appendix B for a copy of this form)

Adult Day Health Care Services are assigned a PA number for the year. Approved units of service are calculated on a weekly basis to the provider and must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning at 12:00 a.m. Sunday and ending at 12:00 a.m. the following Sunday. Payment for services is capped for each week.

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

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**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 units of service. Once post authorization is granted, the service provider may bill the DHH fiscal intermediary for the appropriate units of service.

Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

**Changing Providers**

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

**Changing ADHC Providers**

Recipients may change ADHC providers once every six months. ADHC providers may be changed for good cause at any time as approved by the OAAS regional office.

Good cause is defined as:

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

Recipients must contact their support coordinator to change ADHC providers.

The support coordinator will provide the recipient with the current FOC list of ADHC providers. Once a new provider has been selected, the support coordinator will ensure the new provider is notified of the request. With written consent from the recipient, both the transferring and receiving providers share responsibility for ensuring the exchange of medical and program information which includes:

- Progress notes from the last six months, or if the recipient has received services

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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 Individualized Service Plan,
- Current assessments upon which the Individualized Service Plan is based,
- A summary of the recipient's behavioral, social, health and nutritional status,
- Records tracking recipient's progress towards Individualized Service Plan goals and objectives,
- Documentation of the amount of authorized services remaining in the Plan of Care, including direct service case record documentation, and
- Documentation of exit interview.

The support coordinator will facilitate the transfer of the above referenced information to the receiving ADHC provider and forward copies of the following to the new ADHC provider:

- Most current Plan of Care,
- Current assessments on which the Plan of Care is based,
- Number of services used in the calendar year, and
- All other waiver documents necessary for the new ADHC provider to begin providing services.

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

**Prior Authorization for New ADHC Providers**

The support coordinator will complete a Plan of Care revision form that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the Plan of Care revision. The transferring agency's PA number will expire on the end date as indicated on the Plan of Care revision.

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**Changing Support Coordination Agencies**

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

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

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

After the recipient has selected and been linked by the data contractor to a new support coordination agency, the new agency must inform the transferring agency and complete the FOC file transfer. The new agency must obtain the case record and authorized signature, and inform the transferring agency.

Upon receipt of the completed form, the transferring agency must have provided copies of the following information to the new agency:

- Most current Plan of Care,
- Current assessments on which the Plan of Care is based,
- Number of services used in the calendar year, and
- Most recent six months progress notes.

**NOTE:** The new support coordination agency must bear the cost of copying which cannot exceed the community's competitive copying rate. If the new agency does not receive the information in a timely fashion, the appropriate OAAS regional office should be contacted for assistance.

The transferring support coordination agency shall provide services up to the transfer of records and is eligible to bill for support coordination services for the month in which the dated



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notification is received (transfer of records) by the receiving agency. In the month the transfer occurs, the receiving agency shall begin services within three days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. Immediately after the transfer of records, the receiving agency must submit the required documentation to the data contractor to obtain prior authorization.

**Prior Authorization for New Support Coordination Agencies**

A new PA number will be issued to the new support coordination agency with an effective starting date as the first day of the first full calendar month following the date of the transfer of the records. The transferring agency's PA number will expire on the date of the transfer of the records.

The OAAS or its agent will not backdate the new PA period to the first day of the calendar month in which the FOC and transfer of records are completed. If the new support coordination agency receives the records and admits a recipient in the middle of a month, they cannot bill for services until the first day of the next month.

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**PROVIDER REQUIREMENTS**

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid program, a provider must

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

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

Providers must attend all mandated meetings and training sessions as directed by DHH and/or its designee as a condition of enrollment and continued participation as a waiver provider. A Provider Enrollment Packet must be completed for each DHH administrative region in which the agency will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number and have an adequate Quality Enhancement Plan in accordance with established policy requirements.

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

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

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

Brochures providing information on the agency's experience must include the agency's toll-free number along with the Office of Aging and Adult Service's (OAAS) toll-free information number. OAAS must approve all brochures prior to use.

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Waiver services are to be provided strictly in accordance with the provisions of the approved Plan of Care.

The recipient's support coordination agency and Adult Day Health Care (ADHC) provider must have a written working agreement that includes the following:

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

**Support Coordination Providers**

Providers of support coordination must have a signed performance agreement with OAAS to provide services to waiver recipients. Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined in this manual chapter and the Case Management Services manual chapter. Support coordination agencies will not be able to provide services to waiver recipients or continue on the Freedom of Choice List without an adequate Quality Enhancement Plan in accordance with established policy requirements.

**ADHC Providers**

The ability of an ADHC provider to serve a recipient must be determined on an individual basis. Providers shall not refuse to serve any individual who chooses their agency, unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. Such refusal to serve an individual must be put in writing by the provider.

This written notice must provide a detailed explanation as to why the provider is unable to provide services to the individual. Upon receipt of this written documentation, the support coordinator is to forward same to the OAAS regional office.

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

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- Training policy that includes staff orientation in safety and emergency procedures and no less than 20 hours of face-to-face training per year.
- Employees must possess direct care abilities, skills and knowledge to adequately perform care and assistance as required by waiver recipients,
- Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing and staff coverage plan,
- Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal,
- Identification, notification and protection of recipient's rights both verbally and in writing in a language the recipient/family is able to understand,
- Written grievance procedures,
- Information about abuse and neglect as defined by DHH regulations and state and federal laws, and
- Policies and procedures for the management of involuntary discharges/transfers from their agency.

The ADHC provider's responsibilities related to the management of involuntary transfer/discharge include:

- Submission of a written report to the individual's support coordinator detailing the circumstances leading up to the decision for an involuntary transfer/discharge,
- Provision of documentation of efforts to resolve issues encountered in the provision of services,
- Documentation of team conferences that reflect a person-centered process conducted with the recipient, guardian or responsible representative,
- Notification of and coordination with the support coordinator to update the Plan of Care, and
- Written notification to the recipient or responsible representative at least 15 calendar days prior to the transfer or discharge that shall include:

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- The proposed date of transfer/discharge,
- The reason for the action,
- The names of personnel available to assist the recipient throughout the process, and
- Information on how to request an appeal of the decision via the direct service provider's grievance policy and procedures and/or via the DHH Appeals Bureau.

An ADHC provider is not allowed to impose that recipients attend a minimum number of days per week. A recipient's repeated failure to attend as specified in the Plan of Care may warrant a revision to the plan or possibly a discharge from the waiver. ADHC providers should notify the recipient's support coordinator when a recipient routinely fails to attend the center as specified.

When an ADHC provider reaches licensed capacity, the OAAS regional office should be notified immediately. The provider's name will be removed from the ADHC FOC form until they notify the OAAS regional office that they are able to admit new recipients.

An ADHC provider shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the center's responsibilities are carried out and that the following functions are adequately performed:

- Administrative,
- Fiscal,
- Clerical,
- Housekeeping, maintenance and food service,
- Direct services,
- Supervision,
- Record-keeping and reporting,
- Social services, and
- Ancillary services.

The center shall ensure the following:

- All staff members are properly certified and/or licensed as legally required,

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- An adequate number of qualified direct service staff is present with recipients as necessary to ensure the health, safety and well-being of recipients,
- Procedures are established to assure adequate communication among staff in order to provide continuity of services to recipients to include:
  - Regular review of individual and aggregate problems of recipients, including actions taken to resolve these problems,
  - Sharing daily information, noting unusual circumstances and other information requiring continued action by staff, and
  - Maintenance of all accidents, injuries and incident records related to recipients.
- Employees working with recipients have access to information from case records necessary for effective performance of the employees' assigned tasks,
- A staff member who has knowledge of and can apply first aid and who is certified in CPR must be in the center at all times,
- A staff member shall be designated to supervise the center in the absence of the director,
- A written plan of emergency and safety procedures that includes training staff on their duties when responding to emergencies and evacuating recipients to safe or sheltered areas,
- All furnishings and equipment must be
  - Kept clean,
  - In good repair, and
  - Appropriate for use by the recipients in terms of comfort and safety.

**Quality Enhancement Plan**

Providers must develop a Quality Enhancement Plan (QEP). This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. In accordance with established guidelines, the QEP must be submitted for approval within 60 days after the training is provided by DHH. (See Appendix B for information on obtaining the Quality Enhancement Provider Handbook and associated documents)

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An adequate QEP for providers is valid for a period of one year. Resubmission must be completed no less than 60 days prior to the expiration of the current QEP.

**Changes**

Changes in the following areas are to be reported to Health Standards Section (HSS), OAAS and the Fiscal Intermediary's Provider Enrollment Section in writing at least 10 days prior to any change:

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

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

When a provider agency closes or decides to no longer participate in the Medicaid program, the agency must provide a 30-day written advance notice to recipients and their responsible representatives, support coordination agencies and DHH prior to discontinuing service.

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**SECTION 9.6: STAFFING AND TRAINING****PAGE(S) 3**

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### **STAFFING AND TRAINING**

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

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in 42 CFR 441.404 (b) and La. R.S. 40:1300.51 et seq. Providers of community supported living arrangements services are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must take all reasonable steps to determine whether applicants for employment have histories indicating involvement in abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

Failure to comply with these regulations may result in any or all of the following: recoupment, sanctions, loss of enrollment, or loss of licensure.

#### **Support Coordination Provider Requirements**

**The criteria for staffing and credentialing, in addition to training and supervision, are found in the Case Management Services manual chapter. Support coordination providers should refer to this document to assure compliance with waiver requirements.**

Each regional support coordination agency must have an on-site project manager, support coordinator supervisor and support coordinators.

Contractors of support coordination services cannot “reject” or deny services to any recipient that has been linked to their agency unless one of the following occurs:

- The support coordinator or the support coordination agency is providing direct care service to the recipient, or
- An exception has been given by the Office of Aging and Adult Services (OAAS) for “good cause.”



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Each support coordination provider must ensure that each support coordinator and supervisor possess the minimum requisite skills, qualifications, training, supervision, and coverage in accordance with the requirements described in the Case Management Services manual chapter. In addition, the support coordination agency must maintain sufficient staff and office site(s) to adequately serve recipients in the DHH region(s) where they are enrolled. **All support coordination requirements can be found in the Case Management Services manual chapter.**

**Adult Day Health Care Service Provider Requirements****Staffing Requirements**

Adult Day Health Care staff shall meet the education and experience requirements as required by Louisiana licensing standards for an ADHC facility.

The following staff positions are required in an ADHC. One person may occupy more than one position except for those positions that require full time status. No staff person shall occupy more than three positions at a given time.

<b>ADHC Required Staff</b>	
<b>Position</b>	<b>Specific Requirements</b>
Director (or designee)	Must be accessible to center staff or designated representatives of the DHH at all times
Social Service Designee/Social Worker	Full-time position
Nurse	Full-time position and must be on the premises of the center during all hours that recipients are present
Program Manager	Full-time position
Food Service Supervisor	Full-time position
Direct Service Worker	One full-time staff member to every nine recipients

**Orientation and Training**

A center's orientation program shall provide training for new employees to acquaint them with the philosophy, organization, program, practices and goals of the center. The orientation shall also include instruction in safety and emergency procedures as well as the specific responsibilities of the employee's job.

All employees shall receive training on an annual basis on the following topics:

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- Principles and practices of recipient care,
- The center's administrative procedures and programmatic goals,
- Emergency and safety procedures,
- Recipient rights,
- Procedures and legal requirements concerning the reporting of abuse and neglect,
- Acceptable behavior management techniques,
- Crisis management, and
- Use of restraints (manual method, mechanical or physical devices).

A center shall ensure that each direct care staff completes no less than 20 hours of face-to-face training per year. Orientation and normal supervision shall not be considered for meeting this requirement.

The following individuals shall **not** be employed or contracted by the provider to provide adult day health care services reimbursed through the ADHC Waiver:

- Any person with legal responsibility for the recipient, or
- Any person designated as the recipient's responsible representative.

Family members who provide adult day health care services must meet the same standards for employment as caregivers who are unrelated to the recipient.

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**SECTION 9.7: RECORD KEEPING****PAGE(S) 11**

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**RECORD KEEPING****Components of Record Keeping**

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

A separate record must be maintained on each recipient that supports justification for prior authorization and fully documents services for which payments have been made. The provider must maintain sufficient documentation to enable DHH to verify that prior to payment each charge is due and proper. The provider must make available all records that DHH or its designee, including the recipient's support coordination agency, finds necessary to determine compliance with any federal or state law, rule, or regulation promulgated by DHH.

**Retention of Records**

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

- Until records are audited and all audit questions are answered

OR

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

**NOTE:** Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements and copies of the required documents transferred to the new agency.

**Confidentiality and Protection of Records**

Records, including administrative and recipient, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the recipients or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that

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might identify the recipients or their families. The information may be released only under the following conditions:

- Court order,
- Recipient's written informed consent for release of information,
- Written consent of the individual to whom the recipient's rights have been devolved when the recipient has been declared legally incompetent,
- Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

A provider must, upon request, make available information in the case records to the recipient or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the recipient, that information may be withheld from the recipient except under court order.

The provider may charge a reasonable fee for providing the above records. This fee cannot exceed the community's competitive copying rate.

A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted.

A system must be maintained that provides for the control and location of all recipient records. Recipient records must be located at the enrolled site.

**NOTE:** Under no circumstances should providers allow staff to take recipient's case records from the facility.

**Review by State and Federal Agencies**

Providers must make all administrative, personnel, and recipient records available to DHH and appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of recipient information.

**Administrative Files**

The provider must maintain at a minimum the following information in an administrative file:

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- Documents identifying the governing body,
- List of members and officers of the governing body, their addresses and terms of membership,
- Minutes of formal meetings and bylaws of the governing body, if applicable,
- Documentation of the provider's authority to operate under state law,
- Functional organizational chart that depicts lines of authority,
- All leases, contracts and purchase-of-service agreements to which the provider is a party,
- Insurance policies,
- Annual budgets, audit reports and accounting records,
- Master list of all service providers to whom the provider refers recipients,
- Copy of signed working agreements with all support coordination agencies serving the center's recipients,
- Provider's policies and procedures,
- Documentation of corrective action taken as a result of external or internal reviews,
- Plan for recruitment, screening orientation, ongoing training, development and supervision and performance evaluation of staff,
- Procedures for the maintenance, security, and confidentiality of records that specify who supervises the maintenance of records and who has custody of records,
- DHH approved Quality Enhancement Plan,
- A clear, concise program description, which is made available to the public, detailing:
  - Overall philosophy of the services,
  - Long and short term goals of the services,

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- Target and/or waiver group(s) of recipients served,
  - Intake and closure criteria,
  - Written eligibility criteria for each service provided,
  - Services to be provided,
  - Schedules of fees for services, including a sliding scale, which will be charged to non-Medicaid recipients, if applicable, and
  - Method of obtaining opinion from the recipient regarding recipient satisfaction with services
- 
- A current comprehensive resource directory of existing formal and informal services that addresses the unique needs of elderly people and people with disabilities which must be updated at least annually.
  - Accounting records maintained according to generally accepted accounting principles as well as state and federal regulations and accounting records maintained by the accrual method of accounting.

**NOTE:** Purchase discounts, allowance and refunds will be recorded as a reduction of the cost to which they relate.

- All fiscal and other records concerning services as they are subject at all times to inspection and audit by the Department, the Legislative Auditor, and auditors of appropriate federal funding agencies.
- All required elements/documents as per licensing standards.
- Department approved transportation policy allowing limited mileage radius for recipients, if applicable.

**Personnel Files**

The provider's personnel files must have written employment and personnel policies that include the following:

- Job descriptions for all positions, including volunteers and students that specify duties, qualifications, and competencies.
- Description of hiring practices that includes a policy against discrimination based on race, color, religion, sex, age, national origin, disability, political beliefs, disabled veteran, veteran status or any other non merit factor.

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- Description of procedures for:
  - Employee evaluation,
  - Promotion,
  - Disciplinary action,
  - Termination, and
  - Hearing of employee grievances

**NOTE:** There must be written grievance procedures that allow employees to make complaints without retaliation. Grievances must be periodically reviewed by the governing body in an effort to promote improvement in these areas.

A provider must have a written record on each employee that includes the following:

- Application for employment and/or resume',
- Three references,
- Valid driver's license for operating a vehicle and valid automobile insurance, if relevant,
- Verification of professional credentials required to hold the position including the following, if relevant:
  - Current licensure,
  - Education,
  - Training, and
  - Experience.
- Periodic, at least annual, performance evaluations,
- An employee's starting and termination dates along with salary paid, and
- Copies of criminal records check for all employees.

An employee must have reasonable access to his/her personnel file and must be allowed to add any written statement he/she wishes to make to the file at any time. A provider must not release a personnel file without the employee's written permission except according to state law.

**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER****SECTION 9.7: RECORD KEEPING****PAGE(S) 11****Recipient Records**

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

Progress notes must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note.

**NOTE: General terms such as “called the recipient” or “supported recipient” or “assisted recipient” are not sufficient and do not reflect adequate content. Check lists alone are not adequate documentation.**

The OAAS does not prescribe a format for documentation, but must find all components outlined below. See the following tables for specific information regarding documentation:

**Table of Documentation Schedule**

SUPPORT COORDINATION PROVIDERS			
SERVICE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
At time of activity	At time of activity	At least every 90 days.	Within 14 days of discharge

ADULT DAY HEALTH CARE PROVIDERS			
ATTENDANCE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
Documentation of attendance by indicating date and time of arrival and departure from center.	<b>At least weekly</b> , but any changes in recipient's condition or normal routine should be noted on date of the occurrence.	At least every 90 days.	Within 14 days of discharge



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**Organization of Records, Record Entries and Corrections**

The organization of individual records on recipients and location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.

All entries and forms completed by staff in recipient records must be legible, written in ink and include the following:

- The name of the person making the entry,
- The signature of the person making the entry,
- The functional title of the person making the entry,
- The full date of documentation, and
- Reviewed by the supervisor, if required.

**Any error made by the staff in a recipient's record must be corrected using the legal method** which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a recipient's records.

**Components of Recipient Records**

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

- Identifying information on the recipient recorded on a standardized form including the following:
  - Name
  - Home address
  - Home telephone number
  - Date of birth
  - Sex
  - Race or ethnic origin (optional)
  - Religion
  - Education
  - Marital status
  - Court and/or legal status, including relevant legal documents

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- Representative and Mandate document (i.e., power of attorney), if applicable
- Names, addresses and phone numbers of other recipients or providers involved with the recipient's Plan of Care including the recipient's primary or attending physician
- Date this information was gathered
- Signature of the staff member gathering the information
- Identifying information for the recipient's designated responsible representative and/or emergency contact, if applicable, that includes that individual's:
  - Name
  - Address
  - Telephone number
- Social and medical history including:
  - Diagnoses and any treatments the recipient is receiving
  - History of serious illness, injury or major surgery
  - Allergies to medication
  - A list of all prescribed and non-prescribed medications currently used
  - Current use of alcohol
  - Name of the recipient's personal physician and an alternate
- Any threatening medical condition of the recipient including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or known allergies,
- Complete health records, when available including physical, dental and/or vision examinations,
- Documentation of the need for ongoing services,
- Medicaid eligibility information for Medicaid eligible recipients,
- A copy of assurance of freedom of choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc. signed by the recipient,
- Copy of the recipient's approved Plan of Care,

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.7: RECORD KEEPING****PAGE(S) 11**

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- Copy of the recipient's Individual Service Plan that has been signed and dated by the recipient including:
  - Any subsequent modifications
  - An appropriate summary to guide and assist direct care staff in implementing the recipient's program
- Service documentation describing all contacts, services delivered and/or action taken identifying the recipient(s) involved in service delivery, the date and place of service, the content of service delivery and the services relation to the Individual Service Plan,
- Progress notes and summaries of services and interventions provided and progress toward service objectives (See Progress Notes and Summaries),
- Findings from periodic reviews of the Individual Service Plan including:
  - A summary of the success and failures of the recipient's program
  - Recommendations for any modifications deemed necessary
- A signed physician's order, issued prior to use, when restraints in any form are being used,
- Any grievances or complaints filed by the recipient and the resolution or disposition,
- A log of the recipient's attendance and absences,
- A physician's signed and dated orders for medication, treatment, diet, and/or restorative and special medical procedures required for the safety and well-being of the recipient,
- Reason for case closure and any agreements with the recipient at closure,
- Discharge planning and referral,
- Copies of all pertinent correspondence,
- At least six months of current pertinent information relating to services provided. (Records older than six months may be kept in storage files or folders, but must be available for review.)

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.7: RECORD KEEPING****PAGE(S) 11**

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**NOTE:** Support coordination agencies must meet the requirements outlined in the Case Management Services manual chapter.

**ADHC Progress Notes and Summaries****Progress Notes**

Progress notes are the means of summarizing activities, observations and the recipient's progress. Progress notes must be written at least weekly to document the following:

- Delivery of all services identified in the service plan,
- Approaches identified in the service plan are being carried out by each staff member,
- Progress being made and whether or not the approaches in the service plan are working,
- Changes in the recipient's condition that may indicate a need for a change in the service plan, and
- Completion of incident reports, when appropriate.

**NOTE:** Each individual responsible for providing direct services shall record progress notes at least weekly, but any changes to the recipient's condition or normal routine should be documented on the day of the occurrence.

**Progress Summaries**

Progress summaries must provide a synopsis of all activities for a specified period and must:

- Be completed by a supervisor,
- Indicate who was contacted, where contact occurred, and what activity occurred,
- Summarize activities and actions taken, by whom, and indicate how the recipient is progressing toward the personal outcomes in the Plan of Care and Individual Service Plan,
- Document delivery of services identified on the Plan of Care and the Individual Service Plan,

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.7: RECORD KEEPING****PAGE(S) 11**

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- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and Plan of Care and Individual Service Plan change,
- Be legible (including signature) and include the functional title of the person making the entry and date,
- Be complete and updated in the record at least every 90 days,
- Be recorded more frequently when there is frequent activity or significant changes occur in the recipient's service needs and progress,
- Be signed by the person providing the services, and
- Be entered in the recipient's record when a case is transferred or closed.

Progress notes and summaries must be documented in narrative format that reflects delivery of each service and elaborate on the activity of the contact. The progress notes and summaries must summarize all activities for a specified period which addresses significant activities and progress/lack of progress toward the desired outcomes and changes that may impact the Plan of Care and/or Individual Service Plan and the needs of the recipient. Progress notes and summaries must be sufficient in detail and analysis to allow for evaluation of the appropriateness of the current Plan of Care and Individual Service Plan, allow for sufficient information for use by support coordinators or their supervisors and allow for evaluation of activities by program monitors.

**NOTE:** Support coordination agencies must meet the requirements outlined in the Case Management Services manual chapter.

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.8: REIMBURSEMENT****PAGE(S) 1**

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**REIMBURSEMENT**

Reimbursement for Adult Day Health Care (ADHC) Waiver services shall be a prospective flat rate for each approved unit of service provided to the recipient. Providers must utilize the Health Insurance Portability and Accountability Act compliant billing procedure code and modifier, when applicable. (Refer to Appendix C for information about procedure code, unit of service and current reimbursement rate.)

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

**Support Coordination**

Detailed information regarding the reimbursement of this service can be found in the Case Management Services manual chapter.

**Transition Intensive Support Coordination**

Detailed information regarding the reimbursement of this service can be found in the Case Management Services manual chapter.

**Transition Service**

Detailed information regarding the reimbursement of this service can be found in the Case Management Services manual chapter.

**ADHC**

Claims for ADHC service shall be filed by electronic claims submission 837I or on the UB 04 claim form. Claims must be submitted after the month in which the service was delivered. Claims cannot be span-dated for a specified time-period. Each line on the claim form must represent billing for a single date of service. (Refer to Appendix D for information about claims filing)

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.9: PROGRAM MONITORING****PAGE(S) 6**

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### **PROGRAM MONITORING**

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

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

- Recipient access to needed services identified in the Plan of Care and Individualized Service Plan,
- Quality of assessment and service planning,
- Appropriateness of services provided including content, intensity, frequency and recipient input and satisfaction,
- The presence of the personal outcomes as defined and prioritized by the recipient/guardian, and
- Internal quality improvement.

A sample of recipient records will also be reviewed to assure appropriate services are documented and delivered.

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

#### **On-Site Reviews**

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

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

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.9: PROGRAM MONITORING****PAGE(S) 6**

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**Administrative Review**

The Administrative Review includes:

- A review of administrative records,
- A review of other agency documentation, and
- Provider agency staff interviews as well as interviews with recipients sampled to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the HSS monitoring questions or findings may result in sanctions or liquidated damages and/or recoupment of payment.

**Personnel Record Review**

The Personnel Record Review includes:

- A review of personnel files,
- A review of time sheets,
- A review of the current organizational chart, and
- Provider agency staff interviews to ensure that support coordinators, direct service providers, and all supervisors meet the following staff qualifications:
  - Education,
  - Experience,
  - Skills,
  - Knowledge,
  - Employment status,
  - Hours worked,
  - Staff coverage,
  - Supervisor-support coordinator ratio,
  - Caseload/recipient assignments,
  - Supervision documentation, and
  - Other applicable requirements.



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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.9: PROGRAM MONITORING****PAGE(S) 6**

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**Interviews**

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

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

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

**Recipient Record Review**

Following the interviews, the HSS staff may review the case records of a representative sample of recipients served. The records will be reviewed to ensure that the activities of the provider agency are associated with the appropriate services of intake, ongoing assessment, planning (development of the Plan of Care and Individualized Service Plan, transition/closure, and that these activities are effective in assisting the individual to attain or maintain the desired personal outcomes.

The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the recipients served.

Recorded documentation is reviewed to ensure that the services reimbursed were:

- Identified in the Plan of Care and Individualized Service Plan,
- Provided to the recipient,
- Documented properly,

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.9: PROGRAM MONITORING****PAGE(S) 6**

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- Appropriate in terms of frequency and intensity, and
- Relate back to personal outcomes on the Plan of Care and Individualized Service Plan.

The HSS staff will review the intake documentation of the ADHC waiver recipient's eligibility and procedural safeguards, support coordination and professional assessments/reassessment documentation, service plans, service logs, progress notes and other pertinent information in the recipient record.

**Quality Enhancement Plan**

The provider agency's approved annual Quality Enhancement Plan (QEP) is reviewed to ensure that the agency is providing quality services and is responsive to the needs of recipients, including the personal outcomes defined and prioritized by the recipients. In addition, the following is also reviewed:

- The current approved QEP, any internal corrective action plans and documentation of QEP meetings of the provider agency.
- Recipient input into service planning and timeliness of response to recipient requests in a sample of recipient records.
- The support coordination or direct service provider agency's use of recipient input in the improvement of service provision.

**Monitoring Report**

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

The monitoring report includes:

- Identifying information,
- A statement of compliance with all applicable regulations or,

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.9: PROGRAM MONITORING****PAGE(S) 6**

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- Deficiencies requiring corrective action by the support coordination or ADHC provider agency.

The HSS program managers will review the reports and assess any sanctions as appropriate.

**Corrective Action Report**

The provider is required to submit a Plan of Correction to HSS within **10 working days of receipt of the report**.

The plan must address *how each cited deficiency has been corrected and how recurrences will be prevented*. The provider is afforded an opportunity to discuss or challenge the HSS monitoring findings.

Upon receipt of the written Plan of Correction, HSS program managers review the provider's plan to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the HSS program manager responds to the provider requesting immediate resolution of those deficiencies in question.

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

**Informal Dispute Resolution (Optional)**

In the course of monitoring duties, an informal hearing process may be requested. The provider is notified of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits their rights to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix A for contact information.)

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

The provider is notified of time and place where the informal hearing will be held. The provider should bring all supporting documentation that is to be submitted for consideration. Every effort will be made to schedule a hearing at the convenience of the provider.

The HSS program manager convenes the informal hearing and will conduct the hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the monitoring findings. The provider representatives are advised of the date that a written response will be sent and are reminded of its right to a formal appeal.

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.9: PROGRAM MONITORING****PAGE(S) 6**

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There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the DHH Bureau of Appeals.

**Fraud and Abuse**

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

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**SECTION 9.10: INCIDENTS/ACCIDENTS/COMPLAINTS** **PAGE(S) 3**

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**INCIDENTS, ACCIDENTS AND COMPLAINTS**

Adult Day Health Care (ADHC) providers and support coordinators are responsible for ensuring the health and welfare of the recipient and must report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion. Reporting shall be in accordance with applicable laws, rules and policies and be made to the appropriate agency named below. Only reporting to a supervisor does not satisfy the legal requirement to report. The supervisor shall be responsible for ensuring that reports or referrals are made in a timely manner to the appropriate agency.

**Incident/Accident Reports**

Providers are responsible for documenting and maintaining records of **all incidents and accidents** involving the recipient. A report of the incident/accident shall be maintained in the recipient's record. The report shall include:

- Date of the incident/accident,
- Circumstances surrounding the incident/accident,
- Description of medical attention required,
- Action taken to correct or prevent incident/accident from occurring again, and
- Name of person completing the report.

**Critical Incident Reports**

Additional provider responsibilities apply to incidents defined as critical. Critical incidents include, but are not limited to those involving abuse, neglect, exploitation, extortion, major injury, involvement with law enforcement, major illness, elopement/missing, falls and major medication incidents of the recipient. Critical incidents are fully defined in Office of Aging and Adult Services' (OAAS) *Critical Incident Policy and Procedures* and include the specific provider responsibilities that must be followed. Non-compliance will result in administrative actions. (See Appendix B for information on obtaining this policy)

**Imminent Danger and Serious Harm**

Providers shall report all suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion to the appropriate authorities. In addition, any other circumstances that place the recipient's health and well-being at risk should be reported. (See Appendix A for contact information)

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CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

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SECTION 9.10: INCIDENTS/ACCIDENTS/COMPLAINTS PAGE(S) 3

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

For recipients age 18 through 59, Adult Protective Services (APS) must be contacted. APS investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect, exploitation or extortion.

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

The responsibilities of the support coordination agency and the direct service provider are outlined in the *OAAS Critical Incident Reporting Policy and Procedures*. (See Appendix B for information on obtaining this policy)

### Internal Complaint Policy

Recipients must be able to file a complaint regarding their 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.
- All written complaints should be forwarded to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator.
- The complaint coordinator 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 responsible representative, the employee, and other interested parties. The provider is encouraged to use all available resources to resolve the complaint internally. The employee's supervisor must be informed of the complaint and the resolution.

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SECTION 9.10: INCIDENTS/ACCIDENTS/COMPLAINTS PAGE(S) 3

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- The provider must inform the recipient, the complainant, and/or the responsible representative in writing **within ten working days** of receipt of the complaint and the results of the internal investigation.
- If the recipient is dissatisfied with the results of the internal investigation, he/she may continue the complaint resolution process by contacting the Health Standards Section. (See Appendix A for contact information)

**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER****APPENDIX A – CONTACT INFORMATION****PAGE(S) 1****CONTACT INFORMATION**

<b>OFFICE NAME</b>	<b>TYPE OF ASSISTANCE</b>	<b>CONTACT INFORMATION</b>
OAAS	Provides waiver assistance, clarification of waiver services, receives complaints regarding waiver services	Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031 1-866-758-5035
DHH Bureau of Appeals	Office to contact to request an appeal hearing	Department of Health and Hospitals Bureau of Appeals P. O. Box 4183 Baton Rouge, LA 70821-4183 (225) 342-0443 Fax: (225) 342-8773
Health Standards Section	Office to contact when providers wish to request an informal hearing as the result of a monitoring corrective action report or to file a complaint against a provider agency	Health Standards Section Attn: IDR Program Manager P.O. Box 3767 Baton Rouge, LA 70821 1-800-660-0488
Adult Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of individuals age 18 through 59	1-800-898-4910 or (225) 342-9057
Elderly Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of individuals age 60 or older	1-800-259-4990



## FORMS

Appendix B includes the Request for Payment/Override Form.

Providers are required to follow the procedures that are outlined in the *Quality Enhancement Plan Handbook*. This handbook can be obtained at the following website:

<http://www.dhh.louisiana.gov/offices/publications.asp?ID=105&Detail=514>

Providers are required to follow the procedures that are outlined in the *OAAS Critical Incident Reporting Policies and Procedures* manual and complete all forms as directed by this policy. The manual and forms can be obtained at the following website:

<http://www.dhh.louisiana.gov/offices/page.asp?ID=105&Detail=8982>

## CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

## APPENDIX B – FORMS

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Reissued March 5, 2010 Replaces All Previous Issuances	<b>REQUEST FOR PAYMENT/OVERRIDE FORM</b>	OAAS-PF-08-014 Page 1 of 2
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<b><i>This form will be used for:</i></b>  Request for Payment of Transition Intensive Support Coordination	Request for Payment of Transition Services	Request for Payment of Denied Claims
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Participant Name:	Medicaid # (13 digits):	Date of Birth:	
Agency Name:	Agency Contact Person:	Agency Phone:	
Agency Fax Number:	Agency E-mail Address:		
Population: Check One	EDA	ADHC	Other
Reason for Request:			

  

PA Request is for:	Begin Date: / /	End Date: / /	Initials Only: Date Support Coordination Agency Received the 18-W: / /
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<b>ATTACH ONLY THOSE DOCUMENTS NECESSARY TO JUSTIFY REQUEST:</b> (DHH may request additional information.)			
Approved CPOC	Progress Notes/Typed Chronology	CMS 1500 (completed)	Other:

  

<b>DHH WILL NOT OVERRIDE TIMELY FILING LIMITS.</b> IT IS THE RESPONSIBILITY OF EACH AGENCY TO RECONCILE ALL BILLINGS IN A TIMELY MANNER. DHH WILL REQUIRE A MAXIMUM OF FORTY-FIVE (45) CALENDAR DAYS TO PROCESS ALL REQUESTS AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION. ANY REQUEST NOT CONTAINING THE NECESSARY INFORMATION WILL BE RETURNED AS INCOMPLETE AND CONSIDERED NOT RECEIVED.			
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TO BE COMPLETED BY OAAS:  Notes:	APPROVED	DENIED	RETURNED (See Reason Below)
If Denied or returned, please provide reason below:			

  

OAAS Authorized Reviewer		Date	
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TO BE COMPLETED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) <b>IF APPLICABLE:</b>  Notes:	APPROVED	DENIED	RETURNED (See Reason Below)
If Denied or returned, please provide reason below:			

  

DHH/WAC Authorized Reviewer		Date	
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CHAPTER 9: ADULT DAY HEALTH CARE WAIVER  
APPENDIX B – FORMS

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<p align="center"><b>INSTRUCTIONS FOR COMPLETING REQUEST FOR PAYMENT/OVERRIDE FORM</b></p>	<p align="center"><b>Step One - Indicate Reason for Use of Form.</b></p> <p>1.) <u>Request for Payment of Transition Intensive Support Coordination (TISC)</u> – Use form to request payment for TISC services for up to four months prior to the individual transitioning out of a nursing facility.</p> <p>2.) <u>Request for Payment of Transition Services</u> – Use form to request payment of funds expended by a designated purchaser prior to learning a participant will be unable to transition back into the community with a waiver opportunity..</p> <p>3.) <u>Request for Payment of Denied Claims</u> – Use form to request payment of claims denied by UNISYS.</p>
<p align="center"><b>Step Two - Complete Demographic and Support Coordination Agency Information</b></p>	<p><b>Do not leave any blanks.</b> Indicate the waiver or targeted case management population the request is for.</p> <p align="center"><b>Step Three - Reason for Request:</b></p> <p><b>Be specific.</b> For "Request for Payment of Denied Claims", indicate the reason for the request and include the 3 digit Medicaid claim denial code from the Remittance Advice, i.e., observation services could not be completed because services did not begin until after the quarter, <u>indicate what services did not begin in that quarter and the date the services did begin (this is needed so the PA for the provider can be canceled for that period)</u>, Denial Code 191</p>
<p align="center"><b>Step Four - PA Request is for:</b></p>	<p align="center"><b>Step Five - Date Support Coordination Agency Received the 18-W:</b></p>
<p align="center"><b>Step Six - Support Documents Required:</b></p>	<p>Based on documentation provided, DHH will review and either approve, deny, or return the request.</p> <p>Attach only those documents necessary to justify your request; i.e.</p> <p><b>Request for Payment Reason 1.)</b> Approved POC, progress notes, CMS 1500 (completed), and any other pertinent documents necessary.</p> <p><b>Request for Payment Reason 2.)</b> Copy of Pre-approved Transition Services Expense Planning and Approval (TISEPA) form, copy of revised POC budget sheet, copies of all receipts for expenditures from designated purchaser, copies of canceled checks, and narrative explaining why transition did not take place.</p> <p><b>Request for Payment Reason 3.)</b> If observation of services could not be completed submit program notes or typed chronology that supports request for payment. If denial is for late CPOC due to issues with requesting additional information, attach any correspondence received relative to the delay. <b>PROGRESS NOTES MUST BE LEGIBLE.</b></p>
<p align="center"><b>Step Seven - First Signature Block</b></p>	<p><b>To be completed by OAAS Regional Office (R.O.)</b> - Support coordinator agency will submit completed form and supporting documentation to OAAS R.O. for approval and signature. If denied or returned, the OAAS R.O. will give a detailed explanation for rejection, using an extra sheet if necessary. If approved, OAAS R.O. will e-mail a copy to the support coordination agency, a copy to SRI <a href="mailto:ljarrrett@statres.com">ljarrrett@statres.com</a> for payment, and a copy to <a href="mailto:susan.robinson@la.gov">susan.robinson@la.gov</a> at OAAS State Office (S.O.).</p>
<p align="center"><b>Step Eight - Second Signature Block</b></p>	<p align="center"><b>TO BE USED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) SECTION, WHEN APPLICABLE.</b></p>

Reissued March 5, 2010  
Replaces All Previous Issuance

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**CHAPTER 9: ADULT DAY HEALTH CARE WAIVER**

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**APPENDIX C – BILLING CODES****PAGE(S) 1**

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**ADULT DAY HEALTH CARE (ADHC) WAIVER  
SERVICES PROCEDURE BILLING CODES/RATES  
Effective August 1, 2010**

<b>Provider Type</b>	<b>HCBS Waiver Service Description</b>	<b>Procedure Code</b>	<b>HIPAA Service Description</b>	<b>Units</b>
85	Adult Day Health Care	932	Medical Rehabilitation Day Program – Sub. Category 2 – Full Day	\$63.11 (per diem)
08	Support Coordination	T0012	ADHC Case Management	Monthly \$140.00
08	Transition Intensive Support Coordination	T0013	ADHC High Risk Case Management	Monthly \$157.00
08	Transition Service	T2038	Community Transition, Waiver	\$1,500.00 One time fee

## GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Adult Day Health Care (ADHC) Waiver Manual Chapter.

**Abuse** – The infliction of physical or mental injury on a recipient 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/her health, self-determination, or emotional well-being is endangered. (La. R.S. 15.1503)

**Abuse of Medicaid Funds** – Inappropriate use of public funds by either providers or recipients, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

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

**Adult Day Health Care (ADHC)** – a medical program model designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community based nursing center.

**Adult Day Health Care Center** – any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more adults with functional impairments who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days a week.

**Adult Day Health Care (ADHC) Waiver** – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to adults age 65 or older with functional impairments, or adults between ages 22 and 65 who have a disability according to Medicaid standards.

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

**Allegation of non-compliance** – A claim that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a recipient or recipients. (La. R.S. 40:2009.14)

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CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

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## APPENDIX D – GLOSSARY

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**Allowable Cost** – Those expenses incurred by the provider agency which are reasonable in amount and are necessary for the efficient delivery of support coordination services.

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

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

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

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

**Center for Medicare and Medicaid Services (CMS)** – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

**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).

**Continuous Quality Improvement** – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

**Confidentiality** – The process of protecting a recipient's or an employee's personal information as required by the Health Insurance Portability and Accountability Act (HIPAA).

**Corrective Action Plan** – Written description of action a provider agency plans to take to correct identified deficiencies.

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

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

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**Direct Care Staff** – Unlicensed staff paid to provide personal care or other direct service and support to persons with disabilities or to the elderly to enhance their well-being. This is also referred to as a Direct Service Worker.

**Disabled Person** – A person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for his own care or protection.

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

**Enrollment** – A determination made by DHH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other DHH-funded services. This is also referred to as provider enrollment or certification.

**Exploitation** – The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of an aged person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 15:1503)

**Extortion** – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)

**Fiscal Intermediary** – The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

**Follow-Up** – A core element of service delivery that includes oversight and monitoring of the provision of services to the recipient.

**Formal Services** – Another term for professional and paid services.

**Good Cause** – When the OAAS regional office approves a recipient's change in support coordination or provider agencies outside the timelines noted in policy if one of the following exists: the recipient is moving to another region in the state where the current provider does not provide services; the recipient and provider have unresolved difficulties and mutually agree to a transfer; the recipient's health or welfare has been compromised; or the provider has not rendered services in a manner satisfactory to the recipient.

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

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individuals receiving these services is limited to the number of approved and available waiver opportunities.

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

**Informal Services** – Another term for non-professional and non-paid services provided by family, friends and community/social network.

**Institutionalization** – Placement of a recipient in any inpatient facility including a hospital, group home for people with developmental disabilities, nursing facility, or psychiatric hospital.

**Licensed Practical Nurse (LPN)** – an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse.

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

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

**Medicaid** – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

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

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

**Medicare** – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

**Minimal Harm** – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the consumer’s activities of daily living. (La. R.S. 40:2009.14)



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**Neglect** – The failure by a care giver responsible for an adult’s care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503)

**Nursing Facility (NF)** – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.

**Office of Aging and Adult Services (OAAS)** – The office within the Department of Health and Hospitals that is responsible for the management and oversight of certain Medicaid home and community-based state plan and waiver programs and protective services for adults ages 18 through 59.

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

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

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

**Personal Outcome** – Result achieved by or for the waiver recipient through the provision of services and supports that make a meaningful difference in the quality of the individual’s life.

**Person-Centered Assessment** – The process of gathering and integrating formal and informal information relevant to the development of an individualized POC.

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

**Primary Care Physician** – A physician, currently licensed by the Louisiana State Board of Medical Examiners, who is designated by the recipient or his/her personal representative as responsible for the direction of the recipient’s overall medical care.

**Progress Notes** – Ongoing assessment of the recipient which enables the staff to update the Plan of Care and/or Individualized Service Plan in a timely, effective manner.

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**Provider/Provider Agency** – An agency furnishing Medicaid services under a provider agreement with DHH.

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

**Provider Enrollment** – Another term for enrollment.

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

**Recipient** – An individual who has been certified for medical benefits by the Medicaid program. A recipient certified for Medicaid home and community-based waiver services may also be referred to as a participant.

**Registered Nurse (RN)** – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

**Representative Payee** – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible recipient.

**Responsible Representative** – An adult who has been designated by the recipient to act on his/her behalf with respect to his/her services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without the recipient's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction. This is also referred to as a designated personal representative.

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

**Sexual abuse** – 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

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perform sex with any other person when recipient is not competent to refuse.

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

**Support Coordinator** – An individual who is employed by a public or private entity compensated by the State of Louisiana through Medicaid to create and coordinate a Plan of Care which identifies all services and supports deemed necessary for the recipient to remain in the community as an alternative to institutionalization.

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

**Trivial Report** – A report 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)

**Waiver** – An optional Medicaid program established under Section 1915 (c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care. Services are limited to a finite number of individuals each year as approved by the state legislature and CMS. See also Home and Community-Based Services Waiver.

**Waiver Opportunity** – An opportunity for an eligible application who meets the requirements for institutional care to receive XIX waiver services.

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**CLAIMS FILING**

Claims for Adult Day Health Care Services must be filed by electronic claims submission 837I or on the UB 04 claim form.

This appendix includes the following:

- Instructions for completing the UB 04
- Sample of UB 04 claim form

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## Instructions for Completing the UB04 for Adult Day Health Care

Locator #	Description	Instructions	Alerts
1	Provider Name, Address, Telephone #	<b>Required.</b> Enter the name and address of the facility.	
2	Pay to Name/Address/ID	<b>Situational.</b> Enter the name, address, and Louisiana Medicaid ID of the provider if different from the provider data in Field 1.	
3a	Patient Control No.	<b>Optional.</b> Enter the patient control number. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
3b	Medical Record #	<b>Optional.</b> Enter patient's medical record number (up to 24 characters)	
4	Type of Bill	<p><b>Required.</b> Enter the appropriate 3-digit code as follows:</p> <p><u>1st Digit - Type of Facility</u> 8 = Special Facility (LOC=Adult Day Health Care)</p> <p><u>2nd Digit - Classification</u> 9 = Other (Adult Day Health Care - ADHC)</p> <p><u>3rd Digit – Frequency Definition</u> 1 = Admit Through Discharge Claim. Use this code for a claim encompassing an entire course of treatment for which you expect payment, i.e., no further claims will be submitted for this patient. 2 = Interim - First Claim. Use this code for the first of an expected series of claims for a course of treatment. 3 = Interim - Continuing Claim. Use this code when a claim for a course of treatment has been submitted and further claims are expected to be submitted. 4 = Interim - Final Claim. Use this code for a claim which is the last claim. The "Through" date of this bill (Form Locator 6) is the discharge date or date of death. 7 = Adjustment/ Replacement of Prior Claim. Use this code to correct a previously submitted and paid claim. 8 = Void/Cancel of a Prior Claim. Use this code to void a previously submitted and paid claim.</p>	

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Locator #	Description	Instructions	Alerts
5	Federal Tax No.	<b>Optional.</b>	
6	Statement Covers Period (From & Through Dates) dates of the period covered by this bill.	<b>Required.</b> Enter the beginning and ending service dates of the period covered by this claim (MMDDYY).	
7	Unlabeled	<b>Leave blank.</b>	
8	Patient's Name	<b>Required.</b> Enter the recipient's name exactly as shown on the recipient's Medicaid eligibility card: Last name, first name, middle initial.	
9a-e	Patient's Address (Street, City, State, Zip)	<b>Required.</b> Enter patient's permanent address appropriately in Form Locator 9a-e.  9a = Street address 9b = City 9c = State 9d = Zip Code 9e = Zip Plus	
10	Patient's Birth Date	<b>Required.</b> Enter the patient's date of birth using 8 digits (MMDDYY). If only one digit appears in a field, enter a leading zero.	
11	Patient's Sex	<b>Required.</b> Enter sex of the patient as:  M = Male F = Female U = Unknown	
12	Admission Date	<b>Required.</b> Enter the date on which care began (MMDDYY). If there is only one digit in a field, enter a leading zero.	
13	Admission Hour	<b>Leave blank.</b>	
14	Type Admission	<b>Leave blank.</b>	
15	Source of Admission	<b>Leave blank.</b>	
16	Discharge Hour	<b>Leave blank.</b>	

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Locator #	Description	Instructions	Alerts
17	Patient Status	<p><b>Required.</b> Enter the patient's 2-digit status code as of the "Through" date of the billing period (Form Locator 6).</p> <p><b>Valid Codes</b></p> <p>01 = Discharged to home or self care (routine discharge)</p> <p>02 = Discharged/transferred to another short-term general hospital for inpatient care</p> <p>03 = Discharged/transferred to a skilled nursing facility (SNF) or an intermediate care facility (ICF)</p> <p>04 = Discharged/transferred to another type of institution for inpatient care</p> <p>06 = Discharged/transferred to home under care of home health services organization</p> <p>07 = Left against medical advice or discontinued care</p> <p>09 = Admitted as inpatient to a hospital</p> <p>20 = Expired/Discharged Due to Death</p> <p>30 = Still a patient</p> <p>61 = Discharged/transferred within this institution to hospital-based Medicare approved swing-bed</p> <p>62 = Discharged/transferred to a rehabilitation facility including rehabilitation distinct part units of a hospital</p> <p>63 = Discharged/transferred to a long term care hospital</p>	
18-28	Condition Codes	<b>Leave blank.</b>	
29	Accident State	<b>Leave blank.</b>	
30	Unlabeled Field	<b>Leave blank.</b>	
31-34	Occurrence Codes/Dates	<b>Leave blank.</b>	
35-36	Occurrence Spans (Code and Dates)	<b>Leave blank.</b>	
37	Unlabeled	<b>Leave blank.</b>	
38	Responsible Party Name and Address	<b>Optional.</b>	

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Locator #	Description	Instructions	Alerts
39-41	Value Codes and Amounts	<p><b>Required.</b> Enter the appropriate Value Code (listed below).</p> <p>*80 = Covered days</p> <p>*Enter the appropriate Value Code in the code portion of the field and the Number of Days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.</p>	
42	Revenue Code	<p><b>Required.</b> Enter the applicable revenue code(s) which identifies the service provided.</p> <p><u>Revenue Code &amp; Description (Corresponding Level of Care)</u></p> <p>932 = Medical Rehabilitation Day Program-Subcategory 2 – Full Day (27 = Adult Day Health Care)</p>	
43	Revenue Description	<b>Required.</b> Enter the narrative description of the corresponding Revenue Code as indicated above in Form Locator 42.	
44	HCPSC/Rates HIPPS Code	<b>Leave blank.</b>	
45	Service Date	<p><b>Required.</b> Enter the day of service for each day services are provided (e.g., 01-01, 02-02, 03-03, etc) for each revenue code indicated. Enter a service line for each service day.</p> <p><b>Required.</b> Enter the date the claim is submitted for payment in the block just to the right of the CREATION DATE label on line 23. Must be a valid date in the format MMDDYY. Must be later than the through date in Form Locator 6.</p>	<b>The CREATION DATE replaces the Date of Provider Representative Signature</b>
46	Units of Service	<p><b>Required.</b> Enter 1 unit/day for each day of service.</p> <p><b>Note:</b> ADHC cannot exceed 23 days per month. Enter the number of days of service provided as individual detail lines.</p>	
47	Total Charges	<b>Leave Blank.</b>	
48	Non-Covered Charges	<b>Leave Blank.</b>	



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Locator #	Description	Instructions	Alerts
49	Unlabeled Field (National)	<b>Leave Blank.</b>	
50-A,B,C	Payer Name	<p><b>Situational.</b> Enter insurance plans other than Medicaid on Lines "A", "B" and/or "C". If another insurance company is primary payer, entry of the name of the insurer is <b>required</b>.</p> <p>The Medically Needy Spend down form (110-MNP) must be attached if the date of service falls on the first day of the spend-down eligibility period.</p>	
51-A,B,C	Health Plan ID	<p><b>Situational.</b> Enter the corresponding Health Plan ID number for other plans listed in Form Locator 50 A, B, and C.</p> <p>If other insurance companies are listed, then entry of their Health Plan ID numbers is <b>required</b>.</p>	
52-A,B,C	Release of Information	<b>Optional.</b>	
53-A,B,C	Assignment of Benefits Cert. Ind.	<b>Optional.</b>	
54-A,B,C	Prior Payments	<p><b>Situational.</b> Enter the amount the facility has received toward payment of this bill from private insurance carrier noted in Form Locator 50 A, B and C.</p> <p>If private insurance was available, but no private insurance payment was made, then enter '0' or '0.00' in this field.</p>	
55-A,B,C	Estimated Amt. Due	<b>Optional.</b>	
56	NPI	<b>Required.</b> Enter the provider's National Provider Identifier (NPI)	<b>The 10-digit NPI must be entered here.</b>
57	Other Provider ID	<b>Required.</b> Enter the 7-digit numeric provider identification number which was assigned by the Medicaid Program in 57a.	
58-A,B,C	Insured's Name	<p><b>Required.</b> Enter the recipient's name as it appears on the Medicaid ID card in 58A.</p> <p><b>Situational:</b> If insurance coverage other than Medicaid applies, enter the name of the insured as it appears on the identification card or policy of the other carrier (or carriers) in 58B and/or 58C, as appropriate.</p>	

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Locator #	Description	Instructions	Alerts
59-A,B,C	Pt's. Relationship Insured	<p><b>Situational.</b> If insurance coverage other than Medicaid applies, enter the patient's relationship to insured from Form Locator 50 that relates to the insured's name in Form Locator 58 B and C. Acceptable codes are as follows:</p> <ul style="list-style-type: none"> <li>01 = Patient is insured</li> <li>02 = Spouse</li> <li>03 = Natural child/Insured has financial responsibility</li> <li>04 = Natural child/ Insured does not have financial responsibility</li> <li>05 = Step child</li> <li>06 = Foster child</li> <li>07 = Ward of the court</li> <li>08 = Employee</li> <li>09 = Unknown</li> <li>10 = Handicapped dependent</li> <li>11 = Organ donor</li> <li>13 = Grandchild</li> <li>14 = Niece/Nephew</li> <li>15 = Injured Plaintiff</li> <li>16 = Sponsored dependent</li> <li>17 = Minor dependent of minor dependent</li> <li>18 = Parent</li> <li>19 = Grandparent</li> </ul>	
60-A,B,C	Insured's Unique ID	<p><b>Required.</b> Enter the recipient's 13-digit Medicaid Identification Number as it appears on the Medicaid ID card in 60A.</p> <p><b>Situational.</b> If insurance coverage other than Medicaid applies, enter the insured's identification number as assigned by the other carrier or carriers in 60B and 60C as appropriate.</p>	
61-A,B,C	Insured's Group Name (Medicaid not Primary)	<p><b>Situational.</b> If insurance coverage other than Medicaid applies, enter the Medicaid TPL carrier code of the insurance company indicated in Form Locator 50, on the corresponding line of 61A, 61B, and/or 61C, as appropriate.</p>	
62-A,B,C	Insured's Group No. (Medicaid not Primary)	<p><b>Situational.</b> If insurance coverage other than Medicaid applies, enter on lines 62A, 62B and/or 62C, as appropriate, the insured's number or code assigned by the carrier or carriers to identify the group under which the individual is covered.</p>	
63-A,B,C	Treatment Auth. Code	<b>Leave blank.</b>	

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Locator #	Description	Instructions	Alerts
64-A,B,C	Document Control Number	<p><b>Situational.</b> If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate in 64A.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in 64B.</p> <p>Enter one of the appropriate reason codes for the adjustment or void in 64C. Appropriate codes follow:</p> <p><u>Adjustments</u></p> <p>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></p> <p>10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	To adjust or void more than one claim line, a separate UB-04 form is required for each claim line since each line has a different internal control number.
65-A,B,C	Employer Name	<b>Situational.</b> If insurance coverage other than Medicaid applies and is provided through employment, enter the name of the employer on the appropriate line.	
66	DX Version Qualifier	<b>Leave blank.</b>	
67	Principal Diagnosis Codes	<b>Required.</b> Enter the ICD-9-CM code for the principal diagnosis.	
67 A-Q	Other Diagnosis code	<p><b>Situational.</b> Enter the ICD-9-CM code or codes for all other applicable diagnoses for this claim.</p> <p><b>Note: Use the most specific and accurate ICD-9-CM Diagnosis Code. A three-digit Diagnosis Code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit sub-classifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Diagnosis Codes beginning with “E” or “M” are not acceptable for any Diagnosis Code.</b></p>	

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Locator #	Description	Instructions	Alerts
68	Unlabeled	Leave blank.	
69	Admitting Diagnosis	Optional. Enter the admitting Diagnosis Code.	
70	Patient Reason for Visit	Leave blank.	
71	PPS Code	Leave blank.	
72- A B C	ECI (External Cause of Injury)	Leave blank.	
73	Unlabeled.	Leave blank.	
74	Principal Procedure Code / Date	Leave blank.	
74 a – e	Other Procedure Code / Date		
75	Unlabeled	Leave blank.	
76	Attending	Leave blank.	
77	Operating	Leave blank.	
78	Other	Leave blank.	
79	Other	Leave blank.	
80	Remarks	Situational. Enter explanations for special handling of claims.	
81 a - d	Code-Code – QUAL / CODE / VALUE	Leave blank.	

**Signature is not required on the UB-04.**

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