CHILDREN'S CHOICE WAIVER

Provider Manual

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

November 1, 2005

CHAPTER 14

CHILDREN'S CHOICE

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OVERVIEW

Louisiana Children's Choice Waiver is a Medicaid Home and Community-Based Services waiver that is designed to provide supplemental support services to children with disabilities who currently live at home with their families or will leave an institutional setting to return home. This waiver is unique in that it allows recipients between the ages of birth through 18 years of age to receive a specified monetary amount annually in support services, including support coordination, within a service package individually designed for maximum flexibility. Louisiana Children's Choice Waiver is an optional service that will be offered to as many children as funding allows. Families of children on the current Office for Citizens with Developmental Disabilities (OCDD) Waiver Support and Services Request for Services Registry, which includes the former MR/DD Waiver waiting list, will choose to either apply for the Louisiana Children's Choice Waiver or remain on the Request for Services Registry.

Support services to be provided are specified in the Comprehensive Plan of Care (CPOC). The person-centered planning team, including support coordinators, service providers, family/guardians, and those who know the child best, designs this plan. It is written by the support coordination agency and approved by the OCDD Regional Office staff. The plan of care contains all services and activities involving the recipient, including non-waiver services as well as waiver support services. Recipients are to receive only those support services included in the CPOC and approved by the OCDD Regional Offices. OCDD forwards notification that services are approved (prior authorized) to the direct service provider.

This provider 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 that provide support to such individuals.

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 chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This chapter is intended to give a Louisiana Children's Choice Waiver provider the information needed 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 Departmental rules.

DHH OCDD Waiver Support and Services, is responsible for assuring provider compliance with these regulations and for the licensing of support coordination agencies.

The Licensing and Certification Division of the DHH Health Standards Section (HSS) determines compliance with State licensing requirements for respite services and family support services under the definition of this waiver.

ELIGIBILITY

Initial Eligibility Criteria

Services under the Louisiana Children's Choice Waiver are available only to individuals who meet all the following criteria. The child must continue to meet all waiver eligibility criteria to remain eligible.

Age

The age range is birth through 18 years of age for those children entering the Louisiana Children's Choice Waiver. Children will be transferred to the New Opportunities Waiver (NOW) when they reach age 19 if they continue to meet all waiver eligibility criteria.

Slot Availability

The child's name must be on the statewide MR/DD (NOW) Waiver Request for Services Registry. Names on the registry will be selected in date/time order of the earliest request for services for children of appropriate age. If the family chooses to have the child receive services under Louisiana Children's Choice Waiver, the child's name will be removed from the statewide MR/DD (NOW) Request for Services Registry.

Living Arrangement

The child must live with his/her natural or adoptive family, stepfamily or other relative, legal guardian or with a foster family, or choose to leave an institution to return home to his/her family.

Financial Eligibility

Financial eligibility must be determined for all applicants by the BHSF Medicaid eligibility office. The following eligibility criteria must be met:

- INCOME - must be less than three times the Supplemental Security Income (SSI) amount for the child (excluding consideration of parental income beginning the month after the month of entry into the Louisiana Children's Choice Waiver);
- RESOURCES - less than the SSI resource limit of $2,000 for a child (excluding consideration of parental resources beginning the month after the month of entry into the Louisiana Children's Choice Waiver);

Additional Eligibility Factors:

- DISABILITY - meets Social Security Administration (SSA) definition of disability;
- AGE - birth through 18 years of age;
- CITIZENSHIP - U.S. citizen or qualified alien;
- RESIDENCY - resides in Louisiana;
- ENUMERATION - has or will apply for Social Security number; and
- CONTINUITY OF STAY - has received a waiver service thirty (30) days or more.

Each applicant must meet a separate categorical requirement of disability as defined by the Social Security Administration. If the applicant does not receive SSI, a disability determination is required as part of the eligibility process. The support coordinator will submit medical information to BHSF. The disability determination is made by the BHSF Medical Eligibility Determination Team and ***is separate*** from the medical certification/level of care determination made by OCDD for waiver service eligibility.

Continuity of stay/continuity of care means the individual cannot be certified earlier than thirty (30) days after the first waiver service is provided (at which point coverage can be retroactive to first service, provided all other eligibility criteria is met.)

Exception: Continuity of stay does not apply to SSI recipients.

Application Process

A Louisiana Children's Choice Waiver application (BHSF 1-CC) does not need to be completed for individuals who are certified for Medicaid long term services in a nursing or ICF/MR facility provided: (1) annual eligibility review was done and (2) the individual is transferring directly to the Louisiana Children's Choice waiver. These individuals already meet Medicaid eligibility requirements. If the individual's level of care in the facility was not ICF/MR, another level of care determination must be made by OCDD.

A Louisiana Children's Choice Waiver application (BHSF 1-CC) must be completed for all other applicants, including those already determined eligible under another category of Medicaid assistance such as LaCHIP, CHAMP, and SSI. Additional eligibility criteria (resources, transfer of resources, trusts) are applicable for Louisiana Children's Choice Waiver, which do not apply in some other categories of Medicaid.

The support coordination agencies or OCDD contractor will provide intake services, i.e. interview the family, complete the Medicaid application form and assist in gathering medical and other information necessary for eligibility determination. The support coordination agency will then forward the completed application packet to the BHSF Medicaid eligibility office.

The Louisiana Children's Choice Waiver application packet consists of the following documents:

- BHSF 1-CC - Medicaid Application for Louisiana Children's Choice Waiver
- BHSF Form 148 - Notice of Admit
- BHSF AR - Request for Authorized Representation
- BHSF Form LTC/CS - Choice of Service
- KIDMED Referral
- BHSF Form 90-L - Request for Level of Care Determination

-OR-

- *Children's Choice Comprehensive Plan of Care (CPOC)
- *Psychological Evaluation

*For individuals already receiving SSI, the last two items are not mandatory to submit to BHSF, only to OCDD.

Once the completed packet is received in the Medicaid eligibility office (BHSF), the eligibility examiner will review the application and contact the applicant's family for any needed verification or clarifying information.

Once BHSF receives an approved BHSF Form 142 from OCDD and all other eligibility factors including continuity of stay have been met, the certification can be processed. When all eligibility criteria are met as of the admission date to the waiver, the effective certification date can be retroactive.

A notice of eligibility decision will be sent to the applicant, OCDD, and the support coordination agency.

The initial certification period will be for twelve (12) months, including any retroactive months of eligibility.

Level of Care

Louisiana Children's Choice Waiver is an alternative to institutional care. All applicants must meet the definition of developmental disability as defined in the Glossary Section.

The support coordinator is responsible for collecting the material necessary to make this determination, and convening the person-centered planning team to formulate the comprehensive plan of care, which documents all services to be arranged, including both natural supports and those reimbursed under Louisiana Children's Choice Waiver.

Documentation of level of care and plan of care is submitted to the OCDD Regional Office for a decision to determine if the applicant meets the criteria and level of care requirements for admission to an ICF/MR. ICF/MR and waiver level of care criteria are identical. The OCDD staff assesses the overall support needs of the applicant, including health and welfare, and determines if they will be met by the services and supports designed. Forms to be submitted for initial level of care determination are:

- Form 148 giving requested first date of Louisiana Children's Choice Waiver service;
- Form 90-L completed 90 days or less before the date a Louisiana Children's Choice Waiver service is requested and annually thereafter;
- Special Education 1508 psychological evaluation or other psychological evaluation with supporting assessment documentation from SSI eligibility and/or statement of eligibility from the Office for Citizens with Developmental Disabilities. OCDD reserves the right to require additional assessment should these assessments indicate a level of care not consistent with the criteria for Louisiana Children's Choice Waiver.
- Individual Habilitation Plan (IHP), Individual Education Plan (IEP) and/or Individual Service Plan (ISP) (if available),
- Personal outcomes assessment, and
- A CPOC developed according to person-centered principles.

Choice of Service, Support Coordination and Direct Service Providers

Recipients have freedom of choice concerning whether or not to receive Louisiana Children's Choice Waiver services and may select their support coordination agency and direct service providers.

Support Coordination: Support coordination services are considered an integral part of the process. If a recipient refuses support coordination services, he/she cannot participate in this project.

Recipients who cannot be reached by their support coordinators to arrange for evaluations, service planning, or review of services jeopardize their access to services. Recipients may choose a support coordination agency that is available and can accept new assignments in their region. For the first year, a recipient will remain with the same support coordination agency. Thereafter, a recipient may request a change in support coordination agencies every twelve (12) months or for "good cause".

Direct Service Providers: Recipients have freedom of choice of direct service provider agencies that are available in the region where they live. For the first year, a recipient will remain with the same provider agency. Thereafter, a recipient may change direct service provider agencies every twelve (12) months or at any time for "good cause".

NOTE: See Section 14.7 "Procedures for Changing Direct Service Providers/Support Coordinators" for details on the process of changing service providers.

Earliest Date of Eligibility

Eligibility cannot be effective prior to the date the OCDD approves the Comprehensive Plan of Care (CPOC) and in no instance prior to a pre-certification home visit.

Changes in Recipient Status

Changes in a recipient's income (contributions, earnings, SSA benefits) or resources (cash, property, vehicles, etc.) must be reported to the BHSF eligibility worker as they occur. Other changes that occur in the recipient's situation must also be promptly reported. These changes include change of address, admission to a long term care facility, moves within the state, extended visits or moves out of state, and the number of persons dependent on the recipient for support. Failure to timely report such changes may result in recoupment and/or prosecution.

Person-Centered Comprehensive Plan of Care Changes

The CPOC must be promptly amended to reflect changes in the recipient's situation or service needs. All changes shall be submitted to the OCDD Regional Office for approval. Procedures for developing and revising the CPOC are covered in a separate section of this chapter.

Approved Plan of Care

The comprehensive plan of care (CPOC) developed for the child during the application process must be approved by the OCDD Regional Staff to assure the health and welfare of the applicant/participant and the ICR/MR level of care to be eligible for participation. Health and welfare are assured by the combination of Medicaid services, Louisiana Children's Choice Waiver services, school services, and other supports received through natural and community resources.

Re-determination of Continued Eligibility

Eligibility must be re-evaluated at least annually, or when a change occurs in recipient's circumstances. The BHSF eligibility worker will notify the recipient by letter when financial eligibility must be re-established.

RECIPIENT RIGHTS AND RESPONSIBILITIES

Recipients of these services are entitled to all the rights and responsibilities of a U.S. and Louisiana citizen. Furthermore there are 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 regarding recipient rights.

Freedom of Choice of Program

Applicants/recipients, who qualify for an intermediate care facility for the mentally retarded (ICF/MR) level of care, have the freedom to select institutional or community-based services. Applicants/recipients have the responsibility to participate in the evaluation process. This includes providing the medical and other pertinent information or assisting in obtaining it for use in the person-centered planning process and certification for services. When applicants are admitted to the waiver, they have access to an array of Medicaid services. Please refer to Appendix A of the Medicaid Manual for a listing of services covered by Medicaid.

Notification of Changes

The DHH Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for Louisiana Children's Choice Waiver. In order to maintain eligibility, recipients have the responsibility to inform BHSF of changes in their income, address, and living situation.

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

Neither support coordinators nor service providers may approve or deny eligibility for the waiver or approve services in the waiver program.

Participation in Care

Recipients shall participate in all person-centered planning meetings and any other meeting concerning his/her services and supports. Person-centered planning will be utilized in developing all services and supports to meet the recipient's needs. By taking an active part in planning his/her services, the recipient is better able to utilize the available supports and services.

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

The support coordinator must request changes in the amount of services at least seven (7) days before taking effect except in emergencies. Service providers may not initiate requests for change of service or modify the CPOC without the participation and consent of the recipient.

Freedom of Choice of Support Coordination and Service Providers

At the time of admission to the waiver and every twelve months thereafter, recipients have the opportunity to change support coordination providers, if one is available. Notices will be sent to the recipients every six months explaining the process to change support coordination providers. Support coordinators will provide recipients with their choice of direct service providers and help arrange for the services included in the CPOC.

Recipients have the opportunity to choose service providers initially and every twelve months thereafter unless a change is requested for good cause.

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 Louisiana Children's Choice Waiver is to provide community-based services to individuals who would otherwise require institutionalization. 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.

Compliance with Civil Rights

Recipients have the responsibility to cooperate with providers by not requesting services, which in any way violate state or federal laws. Providers shall operate in accordance with Titles VI and VII of the Civil Rights Act of 1964, as amended, and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. This means that all services and facilities are available to persons without regard to race, color, religion, age, sex, or national origin.

Quality of Care

Louisiana Children's Choice Waiver recipients have the right to receive services from providers who are competent, trained, and qualified.

In cases where services are not delivered according to the CPOC, or there is abuse or neglect on the part of the provider, the recipient shall follow the complaint reporting procedure and cooperate in the investigation and resolution of the complaint. Recipients may not request providers to perform tasks that are illegal or inappropriate and may not violate the rights of providers.

Grievances/Fair Hearings

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 support coordinator shall advise recipients of this right and of their rights to appeal any denial or exclusion from the program or failure to recognize a recipient's choice of a service and of his/her right to a fair hearing through the Medicaid program. In the event of a fair hearing, a representative of the service provider and support coordination agency shall appear and participate in the proceedings.

Rights and Responsibilities of Families

A sample form explaining the rights and responsibilities of families with a child who is an applicant for or recipient of Louisiana Children's Choice Waiver is included in Appendix C. It is written in person-first language and has been developed for sharing with parents and/or families.

PROVIDER REQUIREMENTS

Provider participation in the Louisiana Medicaid program is voluntary. When a provider enrolls in the Medicaid program, he/she agrees to abide by all rules and regulations established by the Federal Centers for Medicare and Medicaid Services (CMS), the DHH Bureau of Health Services Financing (BHSF), and other state agencies if applicable to participation as a provider.

For the Louisiana Children's Choice Waiver Program, services include support coordination and direct services provided by agencies enrolled by Medicaid specifically for this program.

Indication of Agreement

Although this is a voluntary program, enrolled support coordination contractors and direct service providers should note that their signature on a claim form will serve as their agreement to abide by all policies and regulations of the Louisiana Medicaid Program. This agreement also certifies that, to the best of the provider's knowledge, information contained on the claim form is true, accurate, and complete.

Medical Assistance Program Integrity Law (MAPIL)

It is the provider's responsibility to be knowledgeable of all the terms and conditions in MAPIL and in the provider agreement. MAPIL became effective August 15, 1997, and is cited as LAS RS 46:437.1-46: 440.3. It statutorily establishes that the provider agreement is a contract between DHH and the provider, and that the provider voluntarily enters into the agreement. Please refer to Chapter 3 of the Medicaid Manual for the complete policy on this subject.

Terms and conditions imposed on the provider enrolled in with Medicaid by MAPIL include but are not limited to the following:

- Comply with all federal and state laws and regulations;
- Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- Have all necessary and required licenses or certificates;
- Allow for inspection of all records by governmental authorities;
- Safeguard against disclosure of information in recipient's records in accordance with DHH regulations and federal and state laws and regulations governing confidentiality;
- Bill other insurers and third parties prior to billing Medicaid;
- Report and refund any and all overpayments;
- Accept payment in full for Medicaid recipients providing allowances for co-payments authorized by Medicaid;
- Agree to be subject to claims review;

- The buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- Notification prior to any change in ownership;
- Inspection of facilities; and,
- Posting of bond or letter of credit when required.

The BHSF Provider Enrollment section may terminate a provider's enrollment for failure to comply with MAPIL terms or other Medicaid policies.

When OCDD Quality Management staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Surveillance and Utilization Review System (SURS) of the Medicaid Program for investigation and sanctions, if necessary. Specific information regarding fraud, abuse and SURS is found in the Fraud and Abuse chapter of the Medicaid manual. 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.

General Standards for Provider Participation

Providers who wish to participate in the Louisiana Medicaid Program must meet all requirements for licensure, the standards for participation, and the criteria for enrollment.

State laws, rules and regulations, DHH/HSS policies and practices and federal laws define certain standards for participating providers. These standards include but are not limited to the following:

- Agreement to Electronic Funds Transfer (EFT), also known as direct deposit, of Medicaid provider payments.
- Agreement to charge Medicaid no more for services furnished to eligible recipients than is charged on the average for similar services to others.
- Agreement to accept as payment in full the amounts established by the BHSF and not to seek additional payment from the recipient for any unpaid portion of a bill except in cases of spend-down medically needy recipients.
- Agreement to maintain for five years all medical records, remittance advices, and any information regarding payments claimed by the provider for furnishing services.
- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the ***1964 Civil Rights Act***, Section 504 of the Rehabilitation Act of 1973, and, where applicable, Title VII of the 1964 Civil Rights Act.

- Furnish records as requested to the BHSF, its authorized representative, representatives of DHH Health Standards Section (HSS) or the state Attorney General's Medicaid Fraud Control Unit.

Note: It is the provider's responsibility to know and comply with policies regarding provider participation. Refer to Chapter 3 of the Medicaid Manual for further information on this subject.

Support Coordination

Providers of support coordination for the Children's Choice Waiver Program must have a contract with OCDD. Support coordination agencies must meet all of the requirements in their contract in addition to any additional criteria outlined in this chapter.

Direct Service Providers

Direct service providers must maintain a Personal Care Attendant (PCA) License and provide at a minimum the Family Support and Crisis Support. Other direct services outlined below may be provided directly or by an agreement with other agents.

- Family Support - HSS PCA License required. Must be provided by the enrolled agency.
- Crisis Support- HSS PCA License required. Must be provided by the enrolled agency.
- Center Based Respite- HSS Respite License for a facility. May be provided by the enrolled/licensed agency or through an agreement and reimbursed through the enrolled agency.
- Family Training- No license required. Provided by professionals at approved meetings and reimbursed through the enrolled agency.
- Diapers- provided and reimbursed through the enrolled agency.
- Ramp-Home - Appropriate license required. Family agrees with selected provider and payment reimbursed through the enrolled provider.
- Bathroom Modifications - Appropriate license required. Family agrees with selected provider and payment reimbursed through the enrolled provider.
- General Adaptations - Appropriate license required. Family agrees with selected provider and payment reimbursed through the enrolled provider.
- Vehicle Lifts - Appropriate license required. Family agrees with selected provider and payment reimbursed through the enrolled provider.

It will be the responsibility of the enrolled family support provider to reimburse other providers for their services, and maintain records of service delivery in the agency's office located in the appropriate DHH Administration Region.

PROVIDER ENROLLMENT CRITERIA

IMPORTANT NOTE: In order to qualify for enrollment as a Children's Choice Waiver Services Provider, you must first be licensed and enrolled in each DHH Administrative Region in which your agency will provide services, by the DHH Health Standards Section (HSS), as a Personal Care Attendant (PCA) Provider. The PCA licensing and enrollment process is separate and apart from the Children's Choice Waiver Provider enrollment process. If you have not yet obtained licensing and enrollment as a PCA Provider, you must do so before you can be enrolled as a Children's Choice Waiver Provider. PCA licensing and enrollment information can be obtained by contacting HSS at the following address:

Health Standards Section
BHSF Licensing
P.O. Box 3767
Baton Rouge, LA. 70821-3767
(225) 342-0415

Prior to receiving a Provider Enrollment Packet, an applicant must attend the Provider Enrollment Orientation (PEO) conducted by OCDD for waiver service providers. Orientation will be conducted twice each year. If a provider has not attended a PEO within sixty (60) days of acceptance of the enrollment packet, he/she must wait until the next scheduled PEO for enrollment.

A Provider Enrollment Packet must be completed for each DHH Administrative Region in which the agency will provide services. The provider must be enrolled in each region they choose to serve recipients. Each site must house all recipient case records and billing records for recipients who reside in that DHH Administrative Region.

Providers shall serve all recipients in the DHH Administrative Region and shall not refuse to serve any recipient that chooses their agency.

All providers shall maintain a 24 hour toll-free number manned by a person and have a written plan that explains how workers are contacted along with the expected response time to the recipients/families/support coordinators.

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

Providers must have computer equipment and software as specified below to participate in prior authorization and data collection:

- IBM compatible PC with a Pentium processor
- 1.44 MB 3.5 inch disk drive
- 32 MB of RAM or more
- 25 MB free hard drive space or more
- Color monitor
- Printer
- Modem (28.2k or faster)
- CD ROM
- Windows 95 operating system or later version
- Internet account with E-mail and Web-browser software

Training for prior authorization and the data system will be provided once to each agency at no cost to the agency. Training will also be provided on any changes in the system. Any repeat training must be paid for by the requesting agency.

Each provider must have a **Quality Improvement and Self-Assessment Plan**. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first Self-Assessment is due 6 months after approval of the Quality Improvement Plan and yearly thereafter. The Quality Improvement Plan will be due 60 days after training is provided by DHH.

Provider agencies must attend all mandated meetings and trainings as directed by OCDD.
Provider agencies must provide services consistent with Personal Outcomes identified by the recipient and family.

Providers shall maintain and retain all records for a period of five (5) years; maintain a separate record on each recipient which includes complete documentation of the recipient's plan of care, progress notes, time sheets, eligibility documents, and other data.

Provider agencies must have personnel at a minimum level of a supervisor, as outlined in Section 14.11 of this chapter, who has a bachelor's degree in a human service field or R.N. (Diploma, Associate Degree, or Bachelor's degree) and a minimum of one year post degree verifiable work experience in planning and providing direct services to people, birth through 18 years of age, with mental retardation or other developmental disabilities.

Providers must not have been terminated or actively sanctioned by Medicaid, Medicare or other health related programs in Louisiana or any other state.

Providers must not have an outstanding Medicaid program audit exception or other unresolved financial liability owed the state.

Providers must document that criminal record history checks have been obtained and that employees have no criminal history as defined by 42 CFR 441.404 which states that: "Providers of community supported living arrangements services (1) Do not use individuals who have been convicted of child or client abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual; and (2) Take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual."

If the provider chooses to contract with other providers for waiver services other than family support and crisis support, copies of documents signed by owners of both agencies that outline the agreement to accept all recipients must be provided.

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

- Back-up plan for staff coverage for employees who provide direct services and do not report as scheduled;
- How the agency will have staff available at the families' request during an emergency or an unexpected change in schedule;
- Training policy that includes staff training requirements of 16 hours of orientation prior to working with a recipient that must include how to write progress notes. 40 hours per year of work-related training for each employee is required.
- Employees must possess direct care abilities, skills and knowledge to adequately perform care and assistance as required by waiver recipients;
- Written policies and procedures for employment and personnel including: 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;
- Written procedures for the maintenance, security, supervision, confidentiality, organization, transfer, and disposal of records;
- Written policies and procedures that identify and protect the recipient's rights, and procedures for informing the recipient/guardian of these rights both verbally and in writing in a language the recipient/guardian is able to understand;
- Written grievance procedures;
- Written policies and procedures regarding abuse and neglect as defined by DHH regulations and state and federal laws.

Services will be provided only as required by the families in accordance with an approved plan of care.

Providers shall be enrolled for a period of one year. The provider must initiate re-enrollment no less than 60 days prior to expiration of that year.

The agency director or designee shall be available on-site at the request of OCDD for monitoring.

Provider Enrollment Site Visit

When the agency has completed documentation of the enrollment requirements listed in this section, the agency must submit the completed Provider Enrollment Packet to:

Unisys Provider Enrollment
P.O. Box 80195
Baton Rouge, LA 70802

The applicant agency will be contacted by OCDD Quality Management to schedule a site visit upon receipt of the completed packet. The OCDD Quality Management staff will verify compliance with the enrollment requirements during a site visit. If any of the enrollment requirements are not met at the time of the site visit, the applicant agency will be notified in writing within 10 working days regarding the areas needing correction.

The applicant agency must promptly submit appropriate documentation of corrective action taken. If the agency fails to submit the required documentation of corrective action taken within 30 calendar days of the notice of the deficiencies, a recommendation will be made to the Medicaid Program to reject the application for enrollment or terminate the enrollment of an existing provider.

If the agency submits the required documentation of corrective action, the OCDD Quality Management staff will verify that the deficiencies have been corrected. A follow-up site visit may be conducted to ensure that the agency is in complete compliance with all the enrollment requirements.

Once the agency meets all of the enrollment requirements, the OCDD Quality Management Section will submit the necessary documents with a recommendation on enrollment to the Medicaid Provider Enrollment Unit. The service provider should not submit documents directly to the Medicaid Provider Enrollment Unit, as this will delay the enrollment process.

Providers will be added to the Freedom of Choice (FOC) list upon receipt of the Provider Freedom of Choice Request Form, a copy of their Louisiana Medicaid provider number and a copy of the appropriate waiver license.

Change of Address/Enrollment Status

It is the responsibility of all providers to notify the HSS, OCDD and Unisys Provider Enrollment Section should any change occur in the following areas:

- Physical location;
- Mailing address;
- Telephone number;
- Ownership; and
- Account information affecting Electronic Funds Transfer (EFT).

The mailing address of the OCDD is:

OCDD Waiver Supports and Services
446 N. 12th Street
Baton Rouge, LA 70802

The mailing address of the Provider Enrollment Section is:

Unisys Provider Enrollment
P. O. Box 80159
Baton Rouge, LA 70898-0159

Change in Ownership (CHOW)

A change in ownership (CHOW) occurs when a transfer of stock or a change in profit sharing occurs. The provider must notify the fiscal intermediary's Provider Enrollment Unit in writing at the above address prior to any change in ownership. A CHOW, which involves a 5% or more change in stock ownership or profit sharing, requires a new provider number. Therefore, a new provider enrollment packet must be completed. Please refer to Chapter 3 for further information on this subject. Covered Services and Provider Responsibilities

COVERED SERVICES/PROVIDER RESPONSIBILITIES

Covered Services

The array of services described below is provided under the Louisiana Children's Choice Waiver in accordance with the Comprehensive Plan of Care (CPOC), in addition to all regular Medicaid State plan services. This person-centered plan is designed cooperatively by the support coordinator, the recipient, and members of the recipient's support network, which may include family members, service providers, appropriate professionals, and others who know the recipient best. The plan will contain all paid and unpaid services that are necessary to support the recipient in his/her home and promote greater independence.

Effective May 20, 2007, the cost of waiver services including support coordination provided under Louisiana Children's Choice Waiver cannot exceed a service cap of **$17,000 per recipient per year**. Within this annual service cap, the recipient and family, together with the support coordinator, will have the flexibility within the scope of the waiver to select the type and amount of services consistent with the recipient's needs and welfare. This annual cap refers to the cost of approved services provided during the 12-month period addressed by the recipient's CPOC. This limit is not defined by waiver year, calendar year or state fiscal year, but rather by the specific 12-months during which the approved CPOC is in effect. Should the CPOC be amended during the 12-month period, the cap continues to apply for the duration of the original 12-months.

Support Coordination

Support coordination services are mandatory in the Louisiana Children's Choice Waiver. Support coordination consists of coordination of supports and services that will assist recipients who receive Louisiana Children's Choice Waiver services in gaining access to needed waiver and other Medicaid services, as well as needed medical, social, educational and other services, regardless of the funding source. The support coordinator is responsible for convening the person-centered planning team comprised of the recipient, recipient's family, direct service providers, medical and social work professionals, as necessary, and advocates, who determine appropriate supports and strategies to meet the recipient's outcomes. The support coordinator shall be responsible for the ongoing coordination of supports and services included in the recipient's CPOC.

Family Support Services

Family support services are defined as those services provided by a personal care attendant (PCA) directly to the child that enables a family to keep the child or family member with a developmental disability at home, and to enhance family functioning. Services may be provided in the child's home or out of the child's home in such settings as after school programs, summer camps, or other places as specified in the approved CPOC. This does not include services in the worker's home.

Family support includes assistance and prompting with eating, bathing, dressing, personal hygiene, and essential housekeeping chores incidental to the care of the child. Housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the child rather than the recipient's family may be provided. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves.

Family support services also includes the assistance with participation in the community including activities to maintain and strengthen existing informal and natural support networks including transportation to those activities.

Personal care attendant provider agencies must meet state licensure requirements.

*NOTE: **Under this waiver, family support may be performed the same day as EPSDT Personal Care Services (PCS) in Louisiana Children's Choice Waiver. When this occurs, recipient records must reflect the services performed in a detailed manner for monitoring purposes. Family support requires prior authorization from OCDD. PCS services are prior authorized by the Medicaid fiscal intermediary. The differences in Family Support and PCS are listed in the Family Support/PCS chart found in the Appendix.**

Center-Based Respite Care

Center-based respite care is service provided to recipients unable to care for themselves, and it is furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care. Respite care will only be provided in a licensed respite care facility.

Environmental Accessibility Adaptations

Environmental accessibility adaptations are physical adaptations to the home or vehicle. They are provided when required by the recipient's CPOC as necessary to assure the health, welfare and safety of the recipient or which enable the recipient to function with greater independence in the home, and without which, the recipient would require additional supports or institutionalization. Adaptations to the home may include the installations of ramps and/or grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the recipient. Environmental adaptations must be provided by an individual/agency deemed capable by the recipient's family and the direct service provider agency. All providers must meet any state or local requirements for licensure or certification as well as the person performing the service (such as building contractors, plumbers, electricians, or engineers). Providers must complete OCDD-PF-01-006.

When state and local building or housing code standards are applicable, modifications to the home shall meet such standards.

- Adaptations which add to the total square footage of the home are excluded from this benefit.
- All services shall be provided in accordance with applicable State or local building codes.
- An example of adaptation to the vehicle is a van lift.
- Excluded are those adaptations or improvements to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, central air conditioning, a fence, etc.
- Home modification funds are not intended to cover basic construction cost. For example, in a new facility, a bathroom is already part of the building cost. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.
- Fire alarms, smoke detectors, and fire extinguishers are not considered environmental adaptations and are excluded.

Diapers

Based on need, diapers are provided for recipients three years of age and older when necessary for the welfare of the recipient and included in the approved CPOC.

Family Training

Family training consists of training and education for the families of recipients served by Louisiana Children's Choice Waiver. This training and education must be conducted by professional organizations or practitioners who offer education or training appropriate to the needs of the child. It must be individually approved by OCDD, and incorporated in the approved CPOC. For purposes of this service only, "family" is defined as the persons who live with or provide care to a person served by the Louisiana Children's Choice Waiver and may include a parent, spouse, children, relatives, foster family, legal guardian, or in-laws.

Training and education includes reimbursement for travel expenses and registration fees for care givers to attend approved seminars and similar opportunities for knowledge dissemination when such opportunities are approved as appropriate. For the purpose of family training, travel is limited to the continental United States.

Crisis and Non-Crisis Provisions

Families must choose to either accept a slot in the Louisiana Children's Choice Waiver or remain on the MR/DD Waiver Request for Services Registry. This is an individual decision based on a family's current circumstances. A family that chooses Louisiana Children's Choice Waiver may later experience a crisis in circumstances that increases the need for paid supports to a level that cannot be accommodated within the cap on waiver expenditures. A crisis is defined as a catastrophic change in circumstances rendering the natural and community support system unable to provide for the health and welfare of the child at the level of benefits offered under Louisiana Children's Choice Waiver. The following procedure has been developed to address these situations.

Crisis Provision

Definition of a Crisis Situation

To be considered a crisis, one of the following must apply:

- Death of caregiver with no other supports (i.e., other family) available.
- Care giver incapacitated with no other supports (i.e., other family) available.
- Child is committed by court to DHH.
- Other family crisis with no care giver support available, such as abuse/neglect, or a second person in the household becomes disabled and must be cared for by same care giver, causing inability of the natural care giver to continue necessary supports to assure health and safety.
- When the physicians documented condition of the child deteriorates to the point the plan of care is inadequate.

Process for Determining Qualification for Crisis Designation

The family contacts the support coordinator who convenes the person-centered planning team to develop a plan for addressing the change in needs.

The support coordinator is required to exhaust all possible natural and community supports and resources available to the child and family prior to submitting a Request for Crisis Designation to the OCDD Regional Office and submit supporting documentation that resources were researched and unable to be utilized. The support coordinator will contact the OCDD Regional Office for intervention.

If it is determined that there are insufficient natural or community supports available, the support coordinator will complete the Request for Crisis Designation form and submit to the OCDD Regional Office for priority consideration and recommendation.

A CPOC revision must accompany the request for crisis supports, with resource exploration and availability as well as a financial assistance summary attached.

The OCDD Regional Office will:

- Review the request immediately upon receipt to determine if all possible natural and community resources have been explored,
- Determine if a new North Carolina Support Needs Assessment (NC-SNAP) or Health Risk Assessment Tool (HRST) is needed,
- Make a recommendation regarding support(s) needed and the expected duration of the crisis, and
- Forward the Request for Crisis Designation Form to the State Office for final determination.

The OCDD State Office will:

- Review the request and OCDD Regional Office recommendations.
- Make a final determination within 48 hours of receipt of the notice from the regional office, and
- Notify the regional office of the determination.

Provisions of a Crisis Designation

Additional services (crisis support) outside the waiver cap amount may be approved by the OCDD State Office.

Crisis designation is time limited, depending on the anticipated duration of the causative event. Each request for crisis designation may be approved for a maximum of three (3) months initially, and for subsequent periods of up to three (3) months, not to exceed twelve (12) months total or up to the annual CPOC date.

When the crisis designation (i.e. situation meets crisis designation requirements) is extended at the end of the initial duration (or at any time thereafter), the family may request the option of returning the child's name to the original request date on the MR/DD request for services registry when it is determined that the loss of care giver and lack of natural or community supports will be long-term or permanent. OCDD State Office will make this final determination.

Eligibility and services through Louisiana Children's Choice Waiver shall continue as long as the child meets eligibility criteria.

Non-Crisis Provision

Determining Non-Crisis Designation-Other Good Cause

In addition to satisfying crisis provisions, a recipient may also be allowed to restore his or her name to the Request for Services Registry for NOW in original date order in a "non-crisis provision - other good cause criteria" when all of the following four criteria are met:

- The recipient would benefit from services, based on significant changes from baseline OCDD assessments, that are available through NOW, which are not available through his/her current waiver or through Medicaid; **AND**
- The recipient would qualify for those services, based on significant changes from baseline OCDD assessments, under the standards for NOW participants; **AND**
- There has been a change in circumstances, based on significant changes from baseline OCDD assessments, since his or her enrollment in the Children's Choice Waiver causing these other services to be more appropriate. A change in the recipient's medical condition is not required. A change in circumstance can include the loss of in-home assistance through a caretaker's decision to take on or increase employment, or to obtain education or training for employment. Vacations outside the continental U.S. are not considered "good cause", **AND;**
- The person's request date for the NOW has been passed on the Request for Services Registry.

Re-adding the recipient to the Request for Services Registry will allow him or her to be placed in the next available waiver slot that will provide the appropriate services provided the recipient is still eligible when the slot is available.

Recipients being re-added to the Request for Services Registry do not require that the Department immediately offer him/her a waiver slot if all slots are filled. It does not require that the Department make available to this recipient a slot for which another recipient is being evaluated even though that other recipient was originally placed on the Request for Services Registry on a later date.

Waiver services will not be terminated due to the fact that a recipient's name is re-added to the registry for "good cause." The burden of proof for "good cause" (non-crisis provision) is the responsibility of the recipient.

If another MR/DD waiver would provide the recipient with the services at issue, the Department may put the recipient on any waiver that would provide the appropriate services as referenced in criteria for non-crisis provision/other good cause.

If a Children's Choice Waiver recipient's eligibility is terminated based on inability to assure health and welfare of the waiver participant, the Department will restore them to the Request for Services Registry for the MR/DD Waiver in his/her original date order.

Under regulations and procedures applicable to Medicaid fair hearings Children's Choice Waiver recipients have the right to appeal any determination of the Department set forth in the non-crisis provisions.

Process for Non-Crisis/Other Good Cause Designation

The family contacts the support coordinator who convenes the person-centered planning team to establish non-crisis designation and address the change in needs. The support coordinator will contact the OCDD regional waiver specialist for intervention. If it is determined that a non-crisis/other good cause has been fulfilled, the support coordinator will complete the Request for Non-Crisis /Other Good Cause Form and submit to the OCDD Regional Office for consideration and recommendation. A CPOC revision must accompany the request for non-crisis/other good cause provision.

The OCDD Regional Office will:

- Review the request to determine that all four of the criteria have been met.
- Make a recommendation, and
- Forward the request form to OCDD State Office for final determination.

The OCDD State Office will:

- Review the request and OCDD Regional Office recommendations,
- Make a final determination as to whether the individual's name will be returned to the MR/DD Request for Services Registry, and
- Notify the regional office of the recommendations.

INTAKE PROCEDURES FOR SUPPORT COORDINATORS

Intake is the entry point into Support Coordination. Referrals for support coordination services are made only from the OCDD. The required intake procedures are as follows:

- Interview the recipient within three (3) working days of receipt of the Freedom of Choice (FOC), form preferably face-to-face in the recipient's home, and obtain DHH demographic information
- The initial intake process is as follows:
    - When OCDD/contractor notifies the Support Coordination agency of the recipient's choice, the support coordinator begins the Comprehensive Plan of Care (CPOC) process. Upon approval of the required information, the Support Coordination agency will be issued prior authorization to cover services from the beginning date of the CPOC. OCDD will transfer eligibility documents with the transfer of records.
    - Determine the need for immediate Support Coordination intervention.
    - Inform the family of procedural safeguards, rights and grievance procedures which include the following:
    - Determine if the recipient accepts Support Coordination.
    - Advise the recipient of their rights and responsibilities including the right to change support coordination providers and support coordinators, and that waiver services and support coordination are an alternative to institutionalization. Documentation must be in the recipient's record.
    - Obtain the recipient must sign a standardized intake form to verify the above procedural safeguards.

- Determine whether the recipient is receiving Support Coordination from another provider. If so, follow the procedures for changing providers described in this chapter.
- Obtain signed release form(s) from the recipient.
- If Louisiana Children's Choice Waiver supports and services are not appropriate to meet the recipient's needs or if the recipient does not meet eligibility for waiver services, notify the recipient immediately and direct the recipient to other service options, or to the source of the initial referral. If the individual is Medicaid eligible, he/she should be referred to the OCDD Assessment for Support Coordinators

Assessment for Support Coordinators

Assessment is defined as the process of gathering and integrating formal/professional and informal information relevant to the development of an individualized CPOC which is based on, and responsive to the recipient's desired personal outcomes, functional status, and current service needs. The assessment provides foundation for support coordination by defining the recipient's needs and assisting in the development of the CPOC.

Ongoing Assessment Procedures

The assessment must be ongoing to reflect changes in the recipient's life and the changing prioritized personal outcomes over time. These changes include strengths, needs, preferences, abilities, and the resources of the recipient. If there are significant changes in the status of the recipient or their prioritized needs, the support coordinator needs to revise the CPOC.

Time Frames for Assessment

The initial assessment must begin **within seven (7) calendar days** and be completed **within 30 calendar days** of the referral. A reassessment must be completed **within seven (7) calendar days** of notice of a change in the recipient's status.

After the plan has been implemented for a **six-month period**, the support coordinator (with recipient) shall review the CPOC to determine if the needs of the recipient continue to be addressed.

The completed annual reassessment package must be received by OCDD Waiver Operations no later than **thirty-five (35) calendar days**, but as early as **fifty-five (55) calendar days** prior to expiration of the CPOC. Incomplete packages will not be accepted. Support coordinators will be responsible for retrieving incomplete packages from the OCDD Regional Office. Sanctions will be applied. Refer to the Sanctions Chapter for specific details.

Assessment Process

The person-centered support assessments must be conducted by the support coordinator and consists of the following:

- Face to face home interviews with the recipient;
- Direct observation of the recipient;
- Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the recipient;
- Freedom of choice, the availability of all services and support coordination as an alternative to institutionalization.

Characteristics and Components of the Assessment

- May be a standardized instrument for certain targeted populations; identifying information;
- The personal outcomes identified, defined and prioritized by the recipient;
- Medical/physical;
- Psycho social/behavioral;
- Developmental/intellectual;
- Socialization/recreational, including relationships that are important to the recipient and the social environment of the recipient;
- The patterns of the recipient's everyday life;
- Financial resources;
- Educational/vocational;
- Housing/physical environment;
- Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes; and
- Any other information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes. Such information may include input from formal and informal service providers and caregivers as relevant to the personal outcomes.

The assessment should also identify areas where a professional evaluation is necessary to determine appropriate services or interventions.

Responsibilities of the Support Coordinator

The support coordinator must arrange any necessary professional/clinical evaluations needed and ensure recipient choice. The support coordinator also must identify, gather and review the array of formal assessments and other documents that are relevant to the recipient's needs, interests, strengths, preferences and desired personal outcomes.

It is the responsibility of the support coordinator to assist the recipient to arrange professional evaluations and all other components of the assessment to develop strategies for obtaining the services, resources and supports needed to achieve the personal outcomes desired by the recipient. Authorization must be obtained from the recipient to secure appropriate services. In addition, a signed authorization for release of information must be obtained and a copy filed in the case record.

The support coordinator must prepare the annual social summary, handle any other requirements necessary for the Louisiana Children's Choice Waiver recipient and must report and document any incidents/complaints/abuse to the OCDD.

Refer to the Section on Incident/Complaint Reporting for additional instructions.

Note: Evaluations, tests, or reports are NOT covered support coordination activities. The necessary medical, psychological, psycho social or other clinical evaluations, tests, etc. may be covered by Medicaid or other funding sources.

Building and Implementing Supports

The implementation of the CPOC involves arranging for, building and implementing a continuum of both informal supports and formal/professional services that will contribute to the achievement of the recipient's desired personal outcomes.

Responsibilities of the Support Coordinator

- The support coordinator is responsible for building and implementing the supports and services as described in the CPOC.
- Assisting the recipient to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the CPOC.
- Being aware of and providing information to the recipient on potential community resources, including formal resources (Food Stamps, SSI, Housing, and Medicaid) and informal/natural resources, which may be useful in developing strategies to support the recipient in attaining his or her desired personal outcomes.
- Assisting with problem solving with the recipient, supports, and service providers.
- Assisting the recipient to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the CPOC assuring that they meet their individual needs.
- Advocacy on behalf of the recipient to assist them in obtaining benefits, supports or services, i.e. to help establish, expand, maintain and strengthen the recipient's informal and natural support networks. This may involve calling and/or visiting recipients, community groups, organizations, or agencies with or on behalf of the recipient.
- Training and supporting the recipient in self-advocacy, i.e. the selection of providers and utilization of community resources to achieve and maintain his/her desired outcomes.
- Oversight of the service providers to ensure that their recipient receives appropriate services and outcomes as designated in the CPOC.
- Assisting the recipient to overcome obstacles, recognize potential opportunities, and developing creative opportunities.

- Support coordinator meeting with the recipient in a face-to-face after a 6-month period and for each annual development of CPOC or more often if requested by the recipient/family.

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

Monitoring Support Strategies

The support coordinator and the recipient develop an action plan to monitor and evaluate strategies to ensure continued progress toward the recipient's personal outcomes.

Procedures for Monitoring Support Strategies

The support coordinator must at least make phone contact with the recipient every calendar month after linkage to see if there are any issues such as the following:

Does the recipient feel they are meeting their outcome?

Are the times convenient and satisfactory to the recipient?

Are there any problems or changes that require additional services?

Are the providers actually present at the times indicated?

Are the services provided adequate and of quality?

Inform the recipient as to the necessity to contact the support coordinator of significant changes in their status or if problems arise with their service providers. A major change in status requires a reassessment. If it's determined to be a long-term situation, please refer to Crisis Provisions.

Notify service providers within three (3) working days of written changes in the CPOC.

Meet with the recipient after six (6) months of implementation, but no more than nine (9) months after implementation of the CPOC to determine effectiveness of the support strategies and if necessary, to revise the CPOC.

Document all visits and contacts in the case record using the monthly progress notes. Progress notes may be brief as long as all components are addressed. Information documented in the progress notes does not need to be duplicated in the case record.

Monthly progress notes must address personal outcomes separately and reflect the recipient's interpretation of the outcomes and shall include:

- Desired personal outcomes,
- Strategies to achieve the outcomes,
- Effectiveness of the strategies,
- Obstacles to achieving the desired outcomes,
- New opportunities for personal choice, and
- Developing a new action plan.

Coordination of Family Support and Personal Care Services (PCS)

The Personal Care Services (PCS) provider must submit information to the Medicaid fiscal intermediary for prior authorization. Support coordinators will obtain a copy of the PCS prior authorization and give it to the family support provider (if different from the PCS provider) to ensure that the services are not overlapping times. Clear documentation of each service is required in the family support and PCS provider's files. Please see the Family Support/PCS chart in the appendix for a clear delineation of services.

Support Coordination Transition/Closure

The transition or closure of support coordination services must occur in response to the request of the recipient, or if the recipient is no longer eligible for services. The closure process must ease the transition to other services or care systems.

Closure Criteria

Criteria for closure of waiver and support coordination services include but are not limited to the following:

- Recipient requests termination of services.
- Death.
- Permanent relocation of the recipient out of the service area (transfer to another Region) or out of state.
- Long term admission to a hospital, institution or nursing facility.
- Recipient requires a level of care beyond that which can safely be provided through waiver services.
- 30-day hospitalization/institutional rule.
- Recipient refuses to comply with support coordination.

Procedures for Transition/closure

- Transition/closure decisions should be reached with the full participation of the recipient. If a recipient becomes ineligible for services, the support coordinator must notify the recipient immediately.
- The support coordinator must complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient methods of negotiating their own service needs.
- The support coordination agency must notify the OCDD Regional Office of the transition/closure four weeks prior to the closure to allow OCDD to establish a transition plan. Send the closure notice to the following address:

OCDD Waiver Supports and Services
446 N. 12th Street
Baton Rouge, LA 70802-4613

- The agency must follow their own policies and procedures regarding intake and closure.
- The support coordinator must assure that the receiving agency, program or support coordinator receives copies of the most current CPOC and related documents. (The 148 must be completed to reflect the date on the transfer of records and submitted to the appropriate offices.)
- The support coordinator must provide assistance to the recipient and to the receiving agency, program or support coordinator to assure the smoothest possible transition.
- The support coordination agency must serve as a resource to recipients who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities. All closures must be entered into the database immediately.
- The service provider shall be notified immediately.
- An agency shall not close a recipient's case that is in the process of an appeal. Only upon receipt of the appeal decision may the case be closed. If an appeal is requested within ten (10) days, the case remains open. If not requested within ten (10) days, the case will be closed.

Note: All closures must be entered into CMIS immediately by support coordination agencies

COMPREHENSIVE PLAN OF CARE

The Comprehensive Plan of Care (CPOC) is the analysis of information from the formal evaluations and the person-centered supports assessment and is based on the unique personal outcomes identified, defined and prioritized by the recipient.

The CPOC is developed through a collaborative process involving the recipient, family, friends or other support systems, the support coordinator and appropriate professionals/service providers and others who know the recipient best.

It establishes direction for all persons involved in providing supports and services for the recipient, describing how the needed supports and services interact to form overall strategies that assist the recipient to maintain or achieve the desired personal outcomes.

A CPOC is a process for ensuring that the paid medical services and other resources are deemed medically necessary and meet the needs of the recipient including health and welfare, as determined by the assessment and that these services and supports are provided in a cost-effective manner.

It represents a strategy for ensuring that services are appropriate, available, and responsive to the recipient's changing outcomes and needs as updated in the assessment.

The CPOC should not be considered a treatment plan. A treatment plan is the specific clinical interventions which service providers use to achieve treatment or rehabilitation goals. The CPOC should be considered a "master plan". This plan consists of a comprehensive summary of information to aid the recipient to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining their desired personal outcomes.

Required CPOC Procedures

The CPOC must be completed in a face-to-face home visit with the recipient, service provider and members of the support network, which may include family members, appropriate professionals, and others, who are well acquainted with the recipient. The CPOC must be held at a time that is convenient for the recipient.

The CPOC must be outcome-oriented, individualized and time limited. The planning process should include tailoring the CPOC to the recipient's needs based on the on-going personal outcomes assessment. It must develop mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services. The recipient, support coordinator, members of the support system, direct service providers, and appropriate professional personnel must be directly involved in the development of the CPOC. The CPOC must not be completed prior to the CPOC meeting that must include the direct service provider.

The CPOC must assist the recipient to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes which involves assisting them to identify specific, realistic needs and choices for the CPOC. It must also assist the recipient in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes, including action steps, review dates and individuals who will be responsible for specific steps.

The CPOC must incorporate steps that empower and help the recipient to develop independence, growth, and self-management.

The CPOC must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the recipient must be clearly explained. It must be approved prior to issuance of MR/DD14 and service provision.

Required CPOC Components

The CPOC must incorporate the following required components and shall be prepared with the chosen service provider, support coordinator, recipient, parent/family and others at the request of the recipient:

- The recipient's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed, paid formal services;
- Budget payment mechanism, as applicable;
- Target/resolution dates for the achievement/maintenance of personal outcomes;
- Assigned responsibilities:
  - Identify the preferred formal and informal support/service providers and specifying the service arrangements.
  - Identify individuals who will assist the support coordinator in planning, building/implementing supports, or direct services.
  - Ensure flexibility of frequency, intensity, location, time and method of each service or intervention and is consistent with the CPOC and recipient's desired outcomes.
  - Changes in waiver service provider(s) can only be requested by the recipient at the end of a 12- month linkage unless there is "good cause". Any request for a change requires a completion of a FOC form that is to be obtained from the support coordinator.
- All participants present at the CPOC meeting must sign the CPOC;
- The CPOC must be completed and approved as per CPOC instructions;
- The recipient must be informed of his or her right to refuse a CPOC after carefully reviewing it;
- MR/DD14's (Authorization for Services) shall be assigned to providers (support coordination & direct service). See the section on Financial Requirements/Reimbursements.

Required CPOC Time Frames

The completed CPOC and financial eligibility must be completed and received by OCDD Regional Office within thirty-five (35) calendar days from the date of the notification of linkage by OCDD/Contractor. All incomplete packages will be returned.

The CPOC must be reviewed after six months to ensure that the personal outcomes and support strategies are consistent with the needs of the recipient and annually thereafter. It must be submitted to the OCDD Regional Office no later than 35 days prior to expiration.

Routine changes must be submitted seven (7) working days prior to the change (vacations, family, and school out of session). Emergency changes must be submitted within twenty-four (24) hours or the next working day.

The service provider shall be notified of the CPOC approval by the service coordinator within three (3) working day of the receipt of the approval notice. Services in the CPOC shall be implemented within 30 calendar days of notification of the CPOC date.

Implementing The CPOC

- Service provider will follow procedures for obtaining prior authorization of services, monitor his/her expenditures, and notify the case manager when the capped amount is expected to be exhausted prior to the end of the CPOC year.
- Only services in the approved CPOC that have not exceeded the cap shall be reimbursed by Medicaid.
- Provider must have appropriately trained and qualified staff to begin services as outlined in the CPOC.
- Services must be provided at the times requested by the recipient.

Documentation

The CPOC must include the frequency and location of the support coordinators' face-to-face contacts with recipient.

A copy of the approved CPOC must be kept at the recipient's home, in their case record at the support coordination agency, and in the service provider's files. The support coordinator is responsible for providing the copies.

A copy of the CPOC must be made available to all staff directly involved with the recipient.

Note: After the initial CPOC is completed, all ongoing support coordination services must be provided according to the current approved CPOC.

Changes in the CPOC

If there are significant changes (adding or deleting services) in the way the recipient prioritizes their personal outcomes, and/or if there are significant changes in the support strategies or service providers, the support coordinator must revise the CPOC to reflect these changes. A HCW11R change form must be submitted to the OCDD Regional Office for approval on all recipients.

There is flexibility in the CPOC for the family to use the services as needed as long as the reimbursement from Medicaid remains within the cap. Therefore, changes will occur only when a service is added or removed from the CPOC. Below are some examples:

If a recipient's approved CPOC has (1) $100/mo for diapers, (2) home modification - ramp, and (3) family support. (Example includes the $13,500 resources after removal of Support coordination cost.)

The cost of a 12- month supply of diapers will be removed from the $13,500 leaving $12,300 for other use. The cost of the ramp is agreed upon at $800, leaving $11,500. The family may use the $11,500 remaining as needed for family support services for the remainder of the year. The dates and times the services are used is entirely up to the recipient and changes in their schedule do not require a CPOC change.

If after three months the recipient decided it was more important to have additional Family Support services instead of diapers, then the CPOC would be changed to remove diapers. The remaining diaper allowance of $900 would be released from prior authorization and the family would be able to use more family support services as needed.

Initiating a Change in the CPOC

When a change is required, the recipient will contact the support coordinator to call a meeting with the service provider to complete the CPOC revision form. All participants will sign the CPOC revision and the support coordinator will submit to the revision to OCDD Regional Office for approval. The support coordinator will notify the service provider and recipient of the approval/disapproval. The service provider will request prior authorization for approved CPOC revisions.

Note: The annual expiration date of the CPOC never changes.

Direct Service Provider Responsibilities

Involvement from the service provider begins upon notification from the state data contractor that the recipient has chosen their agency to deliver Louisiana Children's Choice Waiver services.

The service provider must:

- Complete the FOC file transfer.
- Obtain the case record that includes the most current six months of progress notes, authorized signature, and inform the transferring service provider agency.
- Participate in the CPOC planning meeting and shall send a representative that has knowledge of the services and can participate appropriately.
- Provide the services that are in the CPOC directly or have agreements to do so. If contracts are used, provider must see that industry standards and appropriate standards (i.e. building codes; transportation standards for vehicle lift) have been met; as well as verification that the job has been completed.
- Notify workers and the recipient of the amount of money that is expended to see that the waiver services cap has not been exhausted. Medicaid will not prior authorize or reimburse for any services over the cap.
- Submit the required data to the OCDD system prior to being reimbursed.
- Track direct service expenditures for each recipient; notifying recipient when funds are low. The direct service provider will be held accountable for any expenditure authorized over the cap.
- Report and document any incidents/complaints/abuse to the support coordinator as well as to the OCDD. Refer to the Section on Incident/Complaint Reporting for additional instructions.

If any enrolled direct service provider agency refuses to serve any recipient without "good cause" approval, the direct service provider agency will be removed from the Freedom of Choice list. Service Providers and Support coordination agencies

CHANGING DIRECT SERVICES PROVIDERS AND SUPPORT COORDINATION AGENCIES

Changing Direct Service Providers

Recipients have freedom of choice of direct service provider agencies that are available in the region where they live. For the first year, a recipient will remain with the same provider agency. Thereafter, a recipient may change direct service provider agencies every twelve (12) months or at any time for "good cause". Refer to the Glossary Section for the definition of "Good Cause".

Once the recipient has decided to change direct service providers, he/she shall notify his/her support coordination agency.

The support coordination agency, through the designated support coordinator, will:

- Provide information to the recipient from the current Freedom of Choice (FOC) listing about service provider options.
- Assist in completing the FOC form and release of information form.
- Inform the transferring service provider agency of the pending transfer.
- Will forward the case record to the services provider.

The new direct service provider obtains the case record from the releasing provider which includes the most current six months of progress notes; time sheets, written documentation of the services provided, documentation of progress toward the individual's goal and outcomes and documentation of authorized services remaining in the OCDD approved CPOC.

Due to the need to coordinate services, it is required that provider changes be made at least seven days prior to the end of the service authorization quarter, unless there is "Good Cause".

Changing Support Coordination Agencies

A recipient may change support coordination agencies after a twelve (12) month period or at anytime for "Good Cause" if the new agency has not met maximum number of recipients. Thereafter, a recipient may request a change in support coordination agencies every twelve (12) months, or for "good cause". Refer to the Glossary section for a description of "Good Cause". Participating support coordination agencies should refer to the *Support Coordination Services Provider Manual* which provides a detailed description of their roles and responsibilities.

Once the recipient has selected a new support coordination agency and the OCDD/Contractor has linked them to a contract provider, the new provider must complete the FOC file transfer. Also, the provider must obtain the case record and authorized signature, and inform the transferring support coordination agency.

Upon receipt of the completed form, the transferring provider must have provided copies of the following information:

- Most current CPOC,
- Current assessments on which CPOC is based,
- Number of services used in the calendar year,
- Most recent six months progress notes, and
- Form 90-L.

Note: The new support coordination provider must bear the cost of copying which cannot exceed the community's competitive copying rate. If the new provider does not receive the information in a timely fashion, the appropriate Program Office should be contacted for assistance.

The transferring support coordination provider shall provide services up to the transfer of records and is eligible to bill for support coordination services after dated 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. The receiving agency must submit the required documentation to OCDD/Contractor to begin prior authorization immediately after the transfer of records.

INCIDENT/COMPLAINT REPORTING FOR SUPPORT COORDINATORS AND SERVICE PROVIDERS

The support coordination agency and the direct service provider are responsible for ensuring the health and safety of the recipient. Recipients shall be free to file a complaint or grievance regarding their support coordinator or service provider without fear of reprisal.

Imminent Danger or Serious Harm

- Call 911 for emergency help or the local law enforcement agency;
- For children under the age of 18, call the local Child Protection Hotline;
- For recipients age 18 or emancipated minors, call the Bureau of Protective Services at 1-800- 898-4910 or (225) 922-2250;
- Initiate an internal investigation;
- Contact the OCDD Complaint Manager within 24 hours at 1-800-660-0488 or by writing the following address:

OCDD Waiver Supports and Services
c/o Complaint Manager
446 N. 12th Street
Baton Rouge, LA 70802
1-800-660-0488

and

- The service provider shall also let the support coordinator know of all incidents/abuse/complaints.

Internal Complaint Process

Less serious complaints are to be handled through the provider's internal complaint process:

- Each agency shall appoint a complaint coordinator to investigate complaints.
- If the complaint is verbal, the provider staff member receiving the complaint must obtain all pertinent information and send all pertinent information in writing to the provider complaint coordinator. If the recipient completes the complaint form, he/she will be responsible for sending the form to the provider complaint coordinator.

- The complaint coordinator shall acknowledge in writing within five (5) working days the receipt of the recipient's complaint.

- The complaint coordinator must thoroughly investigate each complaint using existing policy. The investigation includes but is not limited to the gathering of facts from the recipient and other services providers. These contacts may be either in person or by the telephone. The provider is encouraged to use all available resources to resolve the complaints at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution.

- The provider's administrator or designee must inform the recipient in writing within ten (10) working days of the results of the internal investigation.

- The recipient must be informed that if he/she is dissatisfied with the results of internal investigation he/she may continue the grievance process within thirty (30) calendar days by contacting the OCDD Complaint Manager. The complaint manager can be contacted at:

OCDD Waiver Supports and Services
c/o Complaint Manager
446 N. 12th Street
Baton Rouge, LA 70802
1-800-660-0488

- The OCDD State Office Complaint Personnel will notify the complainant within ten (10) workdays that the complaint has been received and is being investigated, if the complainant's name and address are known.

Complaint Disclosure Statement

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

The OCDD State Office Complaint Program Manager or other OCDD complaint personnel may determine when the complaint is initiated that a disclosure statement is necessary. In addition, the OCDD Regional Office staff may also determine that a disclosure statement may be necessary.

If the OCDD Regional Office staff determines a Complainant Disclosure Statement is necessary, they will contact the OCDD State Office Complaint Personnel who will inform the complainant and give them an opportunity to withdraw the complaint.

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

A copy will be faxed to the OCDD Regional Office staff upon receipt, and further investigation will continue.

Definition of Related Terms Regarding Complaints

For the purposes of the Office for Citizens with Developmental Disabilities complaint process, the words "complaint" and "grievance" will be used synonymously. The following definitions will be used:

- Complaint - an allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a consumer or consumers (La. R.S. 40:2009.14).
- Minimal harm - is an incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the consumer's activities of daily living (La. R.S. 40:2009.14).
- Trivial report - is 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).
- Allegation of noncompliance - is an allegation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers (La. R.S. 40:2009.14).
- Abuse - is the infliction of physical or mental injury on a recipient by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well being is endangered (La. R.S. 14:403.2).
- Exploitation - is the illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of an aged persons or disabled adult's power of attorney or guardianship for one's own profit or advantage (La. R.S. 14:403.2).
- Extortion - is the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority (La. R.S. 14:403.2).
- Neglect - is the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused (La. R.S. 14:403.2).

- Self-neglect - is the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected (La. R.S. 14:403.2).
- Sexual abuse - is any sexual activity between a recipient and staff without regard to consent or injury. Any non-consensual sexual activity between a recipient and another person; or any sexual activity between a recipient and another recipient or any other person when the recipient is not competent to give consent. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the recipient to perform sex with any other person when recipient is not competent to refuse.
- Disabled person - is a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for his/her own care or protection.
- Incident - any situation involving a recipient that is not classified in one of the other categories but indicates the need for awareness by OCDD as it could have some affect on the recipient or the recipient's ability to benefit from their supports and services now or at some time in the future.

STAFFING REQUIREMENTS

The Department of Health and Hospitals (DHH) has the responsibility to establish reasonable qualifications for providers to ensure that they are capable of providing 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 Children's Choice Waiver Program.

Support Coordination Requirements

Each DHH 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 is providing service to the recipient; or
- An exception has been given by the support coordination administrator for irreconcilable differences.

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 DHH requirements described in this section. 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 live within mandated caseload sizes described in this section of this manual. *All DHH support coordination requirements can be found in the DHH Support Coordination Services manual chapter.*

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

Education and Experience

On-site project managers are responsible for the overall operation of the agency and answer to the OCDD for quality assurance and self-evaluation. The education and experience required of the On-Site Project Manager shall be identified by the agency.

NOTE: As stated in Section 14.4 above, employees who work with children in the Louisiana Children's Choice Waiver Program (birth through 18 years) must obtain a criminal history record check to be kept in their personnel files. These forms are obtained from Louisiana State Police.

Support Coordinator

All support coordinators must meet the following minimum qualifications for education and experience:

- A bachelor's degree in a human service-related field including but not limited to psychology, education, counseling, rehabilitation counseling or general studies with a major concentration in a human services-related field from an accredited institution;

  AND

  One (1) year of full-time paid post-degree experience in a human service-related field providing direct recipient services or Support Coordination/service coordination.

  Thirty (30) hours of graduate level course credit in the human service-related field may be substituted for the year of required paid experience.

  OR

- A licensed registered nurse;

  AND

  One (1) year of paid experience as a registered nurse in public health or a human service-related field providing direct recipient services or support coordination/service coordination.

  Thirty (30) hours of graduate level course credit in the human service-related field may be substituted for the year of required paid experience.

  OR

  A bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.

Experience Qualifications

- Experienced gained as part of the educational process, i.e., a field placement, internship or practicum, is part of the qualifying education and may not be counted toward the post-educational experience.
- Experience gained while employed in a position in which ***minimum qualifications were not initially met*** cannot be counted toward the required experience.
- Experience as a teacher does not qualify as direct services.

Support Coordination Supervisor or any Other Individual Supervising Support Coordinators

All support coordination supervisors must meet the qualifications for education and experience listed below.

- A master's degree in social work, psychology, nursing, counseling, rehabilitation counseling, education with special education certification, occupational therapy, speech therapy, physical therapy or general studies with a major concentration in a human services-related field from an accredited institution;

  AND

  Two (2) years of full-time paid post-master's degree experience in a human service-related field providing direct recipient services or Support Coordination/service coordination; one (1) year of this experience must be in providing direct services (teaching is not considered direct services) to people with developmental disabilities;

  OR

- A bachelor's degree in social work from a social work program accredited by the Council on Social Work Education;

  AND

  Three (3) years of full-time paid post-bachelor's degree experience in a human service-related field providing direct recipient services (teaching experience does not apply) or Support Coordination/service coordination; one (1) year of this experience must be in providing direct services to people with developmental disabilities;

  OR

- A licensed registered nurse;

  AND

  Three (3) years of full-time paid experience after licensure as a registered nurse in public health or a human service-related field providing direct recipient services or u/service coordination; two (2) years of this experience must be in providing direct services to people with developmental disabilities;

  OR

- A bachelor's degree in a human service-related field including but not limited to psychology, education, counseling, rehabilitation counseling or general studies with a major concentration in a human services-related field from an accredited institution;

  AND

  Four (4) years of full-time paid post-bachelor's degree experience in a human service-related field providing direct recipient services or Support Coordination/service coordination; two (2) years of this experience must be in providing direct services to people with developmental disabilities. Teaching is not considered direct services.

Thirty (30) hours of graduate level course credit in the human service-related field may be substituted for one (1) year of required experience. All experience must be obtained after completion of the degree or licensure and must be professional level experience.

***Note:** Experience gained as part of the educational process, i.e., a field placement, internship or practicum, is part of the qualifying education and may not be counted toward the post-educational experience.*

Requisite Knowledge, Skills And Abilities

Each Support Coordination provider must look for the basic knowledge, skills, and abilities listed below which are essential to good Support Coordination practice in hiring Support Coordination staff. In addition, each provider must ensure that each staff member providing Support Coordination services possesses this knowledge, skill, and ability prior to assuming full caseload responsibilities:

Knowledge

- Community resources
- Medical terminology
- Support Coordination principles and practices
- Recipient rights
- State and federal laws for public assistance

Skills

- Time management
- Assessment/evaluation
- Interviewing
- Listening

Abilities

- Preparing care plans
- Coordinating delivery of supports and services
- Advocating for the recipient
- Communicating both orally and in writing
- Establishing and maintaining cooperative working relationships
- Maintaining accurate and concise records

- Assessing medical and social aspects of each case and formulating care plans accordingly
- Problem solving
- Remaining objective while accepting the recipient's/guardian's lifestyle

Training For Support Coordination Staff

Support coordinators need ongoing training to maintain and improve their performance. Such training must be provided by or arranged by the support coordinator's employer at the *employer's expense*.

The required orientation and training for support coordinators and supervisors described in this section must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and the orientation/training agenda.

New Employee Orientation

New staff orientation requires at a minimum the following:

- Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment.
- A minimum of eight (8) hours of the orientation training must cover orientation to working with people with developmental disabilities including, but not limited to, specific support and service needs and resources.
- This orientation must include, at a minimum:
  - · Support Coordination provider policies and procedures
  - · Medicaid and other applicable DHH policies and procedures
  - · Confidentiality
  - · Documentation in case records
  - · Recipient rights protection and reporting of violations
  - · Recipient abuse and neglect reporting policies and procedures
  - Recognizing and defining abuse and neglect
  - · Emergency and safety procedures
  - · Data management and record keeping
  - · Infection control and universal precautions
  - · Working with people with developmental disabilities
  - · Professional ethics
  - · Personal outcome measures

Training for New Staff

In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training during the first ninety (90) calendar days of employment.

- This training must be related to working with people with developmental disabilities and specific knowledge, skills, and techniques necessary to provide Support Coordination to people with developmental disabilities.
- This training must be provided by an individual with demonstrated knowledge of both the training topics and the waiver population.
- This training must include, at a minimum, the following:
  - · Assessment techniques
  - · Support and service planning
  - · Resource identification
  - · Interviewing and interpersonal skills
  - · Data management and record keeping
  - · Communication skills
  - · Cultural awareness
  - · Personal outcome measures

A new employee ***may not be given*** Support Coordination responsibility until the orientation is satisfactorily completed.

Note: ***Routine supervision may not be considered training.***

Annual Training for Support Coordinators

It is important for support coordinators to receive continuing training to maintain and improve skills. Each support coordinator must satisfactorily complete forty (40) hours of case-management related training annually which may include training updates on subjects covered in orientation and initial training.

- The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the forty (40) hour minimum annual training requirement.
- Appropriate updates of topics covered in orientation and training for a new support coordinator must be included in the required forty (40) hours of annual training.
- The following is a list of suggested additional topics for training:
  - Nature of illness or disability, including symptoms and behavior
  - Pharmacology

- Potential array of supports and services for people with developmental disabilities
- Building informal and natural support systems
- Family dynamics
- Developmental life stages
- Crisis support and management
- First aid/CPR
- Signs and symptoms of mental illness, alcohol and drug addiction, mental retardation/developmental disabilities and head injuries
- Recognition of illegal substances
- Monitoring techniques
- Advocacy
- Positive behavioral support techniques
- Values clarification/goals and objectives
- Community resources
- Accessing special education services
- Cultural diversity
- Health management
- Team building/interagency collaboration
- Transition/closure
- Age and condition-appropriate preventive health care
- Use of teams/facilitation of teams
- Computers
- Stress and time management
- Legal issues
- Outcome measures
- Person-centered planning
- Self-determination or recipient-directed services
- Child development

Training for Supervisors

Each Support Coordination supervisor must complete a minimum of forty (40) hours of training a year.
In addition to the required and suggested topics for support coordinators, the following are suggested topics for supervisory training:

- •Professional identification/ethics
- •Process for interviewing, screening, and hiring of staff.
- •Orientation/in-service training of staff
- •Evaluating staff
- Approaches to supervision
- Managing caseload size

- Conflict resolution
- Documentation
- Time management

Mandatory DHH Support Coordination Training

Support Coordination agencies must ensure that Support Coordination staff attend and satisfactorily complete mandated DHH training on support coordination policies and procedures. Certificates will be given for attendees and will indicate the hours and training category.

Support Coordination Staff Coverage

All staff and caseload information shall be continuously updated as it occurs, and entered in the database issued by OCDD. This database remains the property of OCDD.

Hours

The support coordination agency must ensure that Support Coordination services are available twenty-four (24) hours a day, seven (7) days a week, through the agency's toll-free number.

- Each support coordinator must be employed forty(40) hours per week and work at least 50% of the time during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday).
- There must be one (1) full time Support Coordination supervisor for every eight (8) support coordinators.
- A supervisor must maintain on-site office hours at least 50% of the time during normal business hours in order to comply with all of the supervision requirements as described in section IV-B.
- A supervisor must also be continuously available to support coordinators by telephone or beeper at all times when not on site.

Note: Contracting with on-site project managers, support coordinator supervisors, and support coordinators is prohibited. Agencies that have a DHH Medicaid Contract may sub-contract with licensed agencies with prior approval by DHH.

Supervision

Each support coordination agency must have and implement a written plan for supervision of all support coordination staff. Support coordinators must be evaluated at least annually by their supervisor according to written provider policy on evaluating their performance.

Supervision of individual staff must include the following:

- Direct review, assessment, problem solving, and feedback regarding the delivery of Support Coordination services;
- Teaching and monitoring of the application of person centered principles and practices;
- Assuring quality delivery of services;
- Managing assignment of caseloads;
- Arranging for training as appropriate; and
- Directing staff in meeting outcomes.

Supervision must be accomplished by a combination of the following means:

- Individual, face-to-face sessions with staff to review individual cases, assess performance and give feedback. Individual face-to-face supervision must occur at least one (1) time per week per support coordinator for a minimum of one (1) hour per week.
- Populations face-to-face sessions with all Support Coordination staff to problem solve, provide feedback and support to support coordinators.
- Sessions in which the supervisor accompanies a support coordinator to meet with the recipient. The supervisor assesses, teaches, and gives feedback regarding the support coordinator's performance related to the particular recipient;
- Supervisors must review at least ten (10) percent of each support coordinator's case records each month for completeness, compliance with these standards, and quality of service delivery.

Sharing Onsite Project Managers

Agencies, having more than one contract where project managers share administrative responsibilities, must submit a plan to the OCDD support coordination Program Administrator. This plan must be approved prior to its implementation. The plan's approval is completely at the discretion of the OCDD Support Coordination Program Administrator and may be terminated at anytime it is determined that the administrative needs of any region are not being met.
The plan must be signed by the contract administrator and include the following information:

- A work plan that outlines the duties of each project manager.
- Outline the projected number of days the managers will be in each office and how they will maintain contact.

Supervisory Record Keeping

Each supervisor must maintain a file on each support coordinator supervised and hold supervisory sessions on at least a weekly basis. The file on the support coordinator must include, at a minimum:

- Date, time, and content of the supervisory sessions; and
- Results of the supervisory case review which must address, at a minimum: completeness and adequacy of records; compliance with standards; and, effectiveness of services.

Caseload Size and Mix

Support Coordination Supervisor

The support coordination supervisor must not supervise more than eight (8) full-time support coordinators or other professional-level human service staff.

- A supervisor may carry 8% of a caseload for each support coordinator supervised when fewer than eight (8). But never more than 50% of their time can be used for caseloads.
- A supervisor carrying a caseload must be supervised by an individual who meets the supervisory qualification as described in this section.
- A plan must be approved by the OCDD Support Coordination Administrator prior to it being implemented.

Support coordinator

- Each full-time support coordinator can have a caseload of no more than thirty-five (35) recipients.
- The caseload mix and size should be monitored by the supervisor to ensure that the support coordinator can adequately manage.

Part-time Support Coordinators

A part-time support coordinator may be used for specific period of time to cover a temporary increase in the number of recipients such as additional waiver slots. In no case can a part-time support coordinator be employed for more than three months. Part-time case mangers must meet all qualification for a support coordinator. All requests must be approved by the OCDD Support Coordination Program Administrator.

Request for approval will be monitored for frequency of request and must contain the following information:

Name of the supervisor:

- An assurance that the agency supervisory personnel will respond in a timely manner during the 40 hour work week, and identify who will be responsible for emergencies that may arise after normal business hours;
- A signed statement by the part-time support coordinator that he/she has no other job;

- A monitoring plan to assure the person's availability and response time to the recipient;
- Plans must be signed by the agency's contract administrator (name on the Board Resolution)

On-Site Project Managers

The responsibilities of the on-site project manager are to supervise the program, direct the staff, communicate with the support coordination contract administrator, implement and carry out Quality Improvement and like administrative duties. These employees shall not carry a caseload or be a supervisor of support coordinators. The exception will be when a *temporary plan* has been submitted for a *temporary* increase in an agencies caseload. All plans must be approved by the support coordination contract administrator prior to implementation.

Direct Service Provider Requirements

Direct service providers cannot reject or deny services to any recipient that has chosen their agency for supports and services unless one of the following occurs:

- The agency is providing support coordination services to the recipient or
- An exception has been granted by the OCDD for "good cause".

Each direct service provider agency must ensure that each direct service staff person possesses minimum requisite skills, qualifications, training, supervision, and coverage in accordance with the DHH requirements in this section. In addition, each direct service provider agency must maintain sufficient staff and office site(s) to adequately serve recipients in the DHH region(s) where they are enrolled.

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

The following individuals shall ***not*** be employed or contracted by the service provider to provide family support services reimbursed through the Children's Choice Waiver:

- Legally responsible relatives (spouses, parents or stepparents, foster parents, or legal guardians); or
- Anyone who lives in the same household with the waiver participant.

Family members who provide family support services must meet the same standards as personal care attendants who are unrelated to the recipient.

NOTE: All employees who work with children (birth through 18 years) in the Louisiana Children's Choice Waiver Program must obtain a criminal history records check and it must be kept in their personnel file. These forms are obtained from Louisiana State Police.

Education and Experience

There are separate requirements for administrative staff and direct service staff.

Administration:

The responsibilities of the agency administrators/directors are to supervise the program, direct the staff, implement and carry out quality improvement and like administrative duties.

Agency directors/administrators are responsible for the overall operation of the agency and are responsible to the OCDD for quality assurance and self-evaluation. The education and experience required of the agency director/administrator shall be identified by the agency.

Each agency must employ a minimum of one employee at the supervisory level or higher who has a bachelor's degree in a human service-related field including but not limited to psychology, education, counseling, rehabilitation counseling or general studies with a major concentration in a human services-related field from an accredited institution; AND one (1) year of paid, full-time post-degree experience in providing direct services people with mental retardation or other developmental disabilities.

OR

An RN (diploma, associate degree, or bachelor's degree) and one year of paid, full time post degree experience in providing direct services to people with mental retardation or other developmental disabilities.

This employee may be part-time, but must meet the following requirements:

- Have consulting availability to the agency,
- Review records and plans for each child at a minimum of every 6 months,
- Must have documented active participation in policy/procedure development and agency staff orientation and annual training,
- Provide a minimum of 4 on-site hours per month of service to the agency.

The enrolled agency must demonstrate that the services delivered by this staff member are adequate to enhance the quality of services delivered by the agency to recipients of Children's Choice. DHH reserves the right to revoke the privilege of this part-time employee if it is determined that the needs of the agency are not being met.

Direct service staff:

Each direct service staff must have a high school diploma or equivalency.

OR

Five (5) years of verifiable work experience in providing direct services to people with mental retardation and/or developmental disabilities. This work experience must be documented in the employee's personnel record.

Requisite Knowledge, Skills, and Abilities

Each direct service provider must look for the basic knowledge, skills, and abilities listed below which are essential to service delivery in hiring direct service staff. In addition, each provider must ensure that each staff member providing direct services possesses this knowledge, skill, and ability prior to working with recipients:

Knowledge

- Community resources
- Medical terminology
- Recipient rights

Skills

- Assessment/evaluation
- Interviewing
- Listening

Abilities

- Following care plans
- Documenting delivery of supports and services
- Advocating for the recipient
- Communicating both orally and in writing
- Establishing and maintaining cooperative working relationships
- Maintaining accurate and concise records
- Problem solving
- Remaining objective while accepting the recipient's/guardian's lifestyle

Training for Direct Service Staff

Direct service staff needs ongoing training to maintain and improve their performance. Such training must be provided by or arranged by the direct service staff's employer at the *employer's expense*.

The required orientation and training for direct service staff and supervisors described in this section must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and the orientation/training agenda.

Orientation for New Employees

New staff orientation requires at a minimum the following:

- Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment.
- A minimum of eight (8) hours of the orientation training must cover orientation to working with people with developmental disabilities including, but not limited to, specific support and service needs and resources.
- This orientation must include, at a minimum:
  - -Direct service provider policies and procedures,
  - -Medicaid and other applicable DHH policies and procedures,
  - -Confidentiality,
  - -Documentation in case records,
  - -Recipient rights protection and reporting of violations,
  - -Recipient abuse and neglect reporting policies and procedures,
  - -Recognizing and defining abuse and neglect,
  - -Emergency and safety procedures,
  - -Data management and record keeping,
  - -Infection control and universal precautions,
  - -Working with people with developmental disabilities,
  - -Professional ethics,
  - -Personal outcome measures,
  - -Training for new staff.

New Employee Training

In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training during the first ninety (90) calendar days of employment.

This training must be related to working with people with developmental disabilities and specific knowledge, skills, and techniques necessary to provide direct services to people with developmental disabilities.

This training must be provided by an individual with demonstrated knowledge of both the training topics and the waiver population.

This training must include the following at a minimum:

- Assessment techniques,
- Support and service delivery,
- Resource identification,
- Interviewing and interpersonal skills,
- Data management and record keeping,
- Communication skills,
- Cultural awareness,
- Personal outcome measures.

A new employee ***may not be given*** direct support work responsibility until the orientation is satisfactorily completed.

Note: Routine supervision may not be considered training.

Annual Training for Direct Care Staff

It is important for direct service staff to receive continuing training to maintain and improve skills. Each direct service staff must satisfactorily complete forty (40) hours of direct service related training annually which may include training updates on subjects covered in orientation and initial training.

The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the forty (40) hour minimum annual training requirement.

Appropriate updates of topics covered in orientation and training for a new support coordinator must be included in the required forty (40) hours of annual training.

The following is a list of suggested additional topics for training:

- -Nature of illness or disability, including symptoms and behavior;
- -Pharmacology;
- -Potential array of supports and services for people with
- developmental disabilities;
- -Building informal and natural support systems;
- Family dynamics
- -Developmental life stages;
- -Crisis support and management;
- -First aid/CPR;
- Signs and symptoms of mental illness, alcohol and drug; addiction, mental retardation/developmental disabilities and head injuries;
    - -Recognition of illegal substances;
    - -Advocacy;
    - -Positive behavioral support techniques;
    - -Values clarification/goals and objectives;
    - -Community resources;
    - -Positioning & physical management;
    - -Cultural diversity;
    - -Health care management including preventive health care;
    - -Team building/membership/interagency collaboration;
    - -Team membership in human service;
    - -Stress and time management;
    - -Legal issues;
    - -Outcome measures;
    - -Person-centered planning;
    - -Self-determination or recipient-directed services;
    - -Human development.

Training for Supervisors

Each direct service provider supervisor must also complete a minimum of forty (40) hours of training a year. In addition to the required and suggested topics for support coordinators, the following are suggested topics for supervisory training:

- Professional identification/ethics;
- Process for interviewing, screening, and hiring of staff
- Orientation/in service training of staff;
- Evaluating staff;
- Approaches to supervision;
- Managing workloads;
- Conflict resolution;
- Documentation;
- Time management.

Mandatory DHH Training

Direct service agencies must ensure that direct service staff attend and satisfactorily complete mandated DHH training. Certificates will be given for attendees and will indicate the hours and training category.

Direct Service Provider Staff Coverage

The following is a description of the requirements for service times.

Hours

The direct service provider agency must ensure that recipients can access the agency twenty-four (24) hours a day, seven (7) days a week, through a toll-free number.

A supervisor must also be continuously available to direct care staff by telephone or beeper at all times when not on site.

Supervision

The direct service provider must have and implement a written plan for supervision of all direct service staff. Direct service staff must be evaluated at least annually by their supervisor according to written provider policy on evaluating their performance.

Supervision of individual staff must include the following:

- Direct review, assessment, problem solving, and feedback regarding the delivery of services;
- Teaching and monitoring of the application of person centered principles and practices;
- Assuring quality delivery of services;
- Managing work assignments;
- Arranging for training as appropriate;
- Directing staff in meeting outcomes;
- Supervision must be accomplished by a combination of the following means:

  -Individual, face-to-face sessions with staff to review individual cases, assess performance and give feedback. Individual face-to-face supervision must occur at least one (1) time per month per direct service staff for a minimum of one (1) hour per month.

  -Face-to-face sessions with all direct service staff to problem solve, provide feedback and support to staff.

  -Sessions in which the supervisor accompanies a direct service staff to meet with the recipient. The supervisor assesses, teaches, and gives feedback regarding the direct service staff's performance related to the particular recipient.

Sharing Directors/Administrators

Agencies having more than one site where directors/administrators share administrative responsibilities must submit a plan to the OCDD. This plan must be approved prior to its implementation. The plan's approval is at the discretion of the OCDD and can be terminated at anytime it is determined that the administrative needs of any region are not being met.

The plan must be signed by the administrator and include the following information:

- A work plan that outlines the duties of each director/administrator.
- Outline the projected number of days the administrator/director will be in each office and how they will maintain contact.

Supervisory Record Keeping

Each supervisor must maintain a file on each direct service staff supervised and hold supervisory sessions on at least a weekly basis. The file on the direct service staff must include, at a minimum:

- Date, time, and content of the supervisory sessions and
- Results of the supervisory case review which must address, at a minimum: completeness and adequacy of records; compliance with standards; and, effectiveness of services.

All case assignments should be monitored by the supervisor to ensure that the direct service staff can adequately manage their caseload.

RECORD KEEPING/DOCUMENTATION

The following is the information necessary to document the waiver participant's records for service and financial reviews pertaining to the administration of the waiver.

Components of Record Keeping

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

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

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

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.

Records, including administrative and recipient, must be the property of the provider, and he/she must secure the records 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 might identify the recipients or their families. The information may be released only under the following conditions:

- By court order.
- By the recipient's written, informed consent for release of information.
- When the recipient has been declared legally incompetent, the individual to whom the recipient's rights have devolved provides written consent.
- When the recipient is a minor, the parent or legal guardian provides written consent.
- In 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 recipient. 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.
- A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge or the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted.

NOTE: A reasonable fee may be charged for providing the above records.

*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's administrative files must include at a minimum:

- 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 by-laws 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,
- 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,
- Quality Improvement 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;

  -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;

-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 children with developmental disabilities and communities served 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.

Personnel Files

The provider must have written employment and personnel policies that include:

- 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.
- Description of procedures for:

-Employee evaluation

-Promotion

-Disciplinary action

-Termination

-Hearing of employee grievances

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:

- Application for employment and/or resume';
- Three (3) references;
- Valid driver's license for operating a vehicle and valid automobile insurance;
- 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;
- 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.

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 OCDD does not prescribe a format for documentation but must find all components outlined below. The schedule for documentation differs based on each waiver/service system. See the Table for Documentation Schedule at the end of this section.

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 include:

- The name of the person making the entry;
- A legible signature of the person making the entry;
- A functional title of the person making the entry;
- The full date of documentation;

They must also be legible, in ink and reviewed by the supervisor.

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.

(a) Active Record

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)
  -Closest living relative
  -Education
  -Marital status
  -Name and address of current employment, school, or day program as appropriate

-Date of initial contact
-Court and/or legal status, including relevant legal documents
-Names, addresses, and phone numbers of other recipients or providers involved with the recipient's CPOC including the recipient's primary or attending physician
-Date this information was gathered
-Signature of the staff member gathering the information

- Documentation of the need for ongoing services.
- Medicaid eligibility information for Medicaid eligible recipients.
- A copy of assurances of freedom of choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc. signed by the recipient.
- Complete service plan as specified in the Services Section of this manual signed and dated by the recipient.
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives.
- Reason for case closure and any agreements with the recipient at closure.
- Copies of all pertinent correspondence.
- At least six (6) months of current pertinent information relating to services provided. Records older than six (6) months may be kept in storage files or folders, but must be available for review.
- 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.
- Monitoring reports of waiver service providers to ensure that the services outlined in the Comprehensive Plan of Care are delivered as specified.
- Service logs describing all contacts, services delivered and/or action taken identifying the recipients involved in service delivery, the date and place of service, the content of service delivery and the services relation of the contact to the CPOC.

(b) Service Logs

Service logs document the services billed. Service logs must reflect service delivered and are the "paper trail" for services delivered.

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

- Name of recipient,
- Name of provider and employee providing the service,
- Service agency contact telephone number,
- Date of service contact,
- Start and stop time of service contact,
- Place of service contact,
- Purpose of service contact:

  -Personal outcomes addressed
  -Other issues addressed
- Content and outcome of service contact.

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

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

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

Each direct service provider's documentation should support justification for prior authorization or payment of services.

(c) ***Progress*** *Notes* **(Summary)** Progress notes are the means of summarizing activities, observations and progress toward meeting service goals in the CPOC. Progress notes and summaries must:

- Indicate who was contacted, where contact occurred, and what activity occurred.
- Record activities and actions taken, by whom, and progress made; and indicate how the recipient is progressing toward the Personal Outcomes in the CPOC.

- Document delivery of each service identified on the CPOC.
- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and CPOC 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 preferably weekly, but at least monthly and signed by the person providing the services, support coordinators or direct service agency staff.
- Be recorded more frequently (weekly) when there is frequent activity or significant changes occur in the recipient's service needs and progress.

Each support coordination agency shall document progress as a narrative that reflects each entry into the service log and elaborate on the substance of the contact. The progress notes shall summarize all activities for a specified period that addresses significant activities and progress/lack of progress toward the desired outcomes and changes in the social history.

NOTE: ***This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other support coordinators or their supervisors, and allow for evaluation of activities by program monitors.***

Each direct service provider shall document progress as a narrative that reflects each entry into the service log/payroll sheet and elaborate on the activity of the contact. The progress notes shall 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 CPOC and the needs of the individual.

NOTE: ***This summary should be sufficient in detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other direct support staff or their supervisors, and allow for evaluation of activities by program monitors.***

A summary must also be entered in the recipient's record when a case is transferred or closed.

Table of Documentation Schedule

SUPPORT COORDINATION PROVIDERS				
WAIVER	SERVICE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
Children's Choice	At time of activity	At time of activity	Between 6th and 9th month or more frequently if indicated.	Within 14 days of discharge
DIRECT SERVICE PROVIDERS				
WAIVER	SERVICE LOG/ PAYROLLSHEET	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
Children's Choice	At time of activity	At time of activity	Between 6th and 9th month or more frequently if indicated.	Within 14 days of discharge

PRIOR AUTHORIZATIONS/FINANCIAL REIMBURSEMENTS

In order to be reimbursed for the services, the provider has to first obtain prior authorization for the service and then bill on a monthly basis for the service.

Prior Authorization

The procedures for issuing prior authorization (PA) numbers for Louisiana Children's Choice Waiver support coordination recipients are as follows:

New Support Coordination Recipients

Freedom of Choice (FOC) forms for support coordination are provided to the recipient only by OCDD. OCDD or its agent receives FOC form from the recipient or OCDD.

The OCDD or its agent links the recipient to his/her choice of agency, depending on availability.

The OCDD or its agent notifies the linked agency of a new recipient by mailing the agency the FOC form with a workday report. In addition, the OCDD or its agent notifies the recipient of the assigned agency. Only linkages from the OCDD or its agent are valid.

The OCDD or its agent shall receive the Requested Waiver Services and Approval Page of the CPOC from the support coordination agency by mail no more than 60 days from the CPOC date. This information will not be accepted by phone or fax.

The PA number is issued with an effective starting date no earlier than the later of the following:

The PA will start 35 days prior to the OCDD Regional Office packet receipt date as indicated on the CPOC Approval Page, but not before the CPOC signature date, or the Freedom of Choice Date.

OR

No more than 60 days prior to the OCDD or its agent packet receipt date requesting a PA. The PA period will end one month after the end of a fiscal quarter – January 31, April 30, July 31, or October 31.

Support Coordination Reimbursement

Louisiana Children's Choice Waiver support coordination is billed on a CMS 1500 to the fiscal intermediary using procedure code 9E001 as the specific billing code. See Chapter 7 (A) for billing instructions.

Renewal Prior Authorizations (PA)

The OCDD or its agent will automatically issue PAs for Louisiana Children's Choice Waiver recipients beginning the first day of the month after the current PA ends. Renewals will be for a 6 month period.

Transfer of Recipient

FOC Forms for support coordination are provided to the recipient only by the OCDD or its agent.

The OCDD or its agent will notify the linked agency of a new recipient by mailing the agency the FOC form indicating the transferring agency attached to the workday journal. The OCDD or its agent will also notify the recipient of the assigned agency. Only linkages from the OCDD or its agent are valid.

The receiving agency must contact the transferring agency to obtain the required records. Both the transferring and receiving agencies complete the Transfer of Records Form. The receiving agency is responsible for delivering services to the recipient beginning on the transfer of records date. The transferring agency is responsible for delivering services to the recipient through the transfer of records date. Therefore, to assure payment to the agency performing the task, the transfer should take place as close to the end of the month as possible. The receiving agency mails the completed Freedom of Choice/Transfer of Records Form to the OCDD or its agent. The Transfer of Records Form will not be accepted by phone or fax.

A new PA number will be issued with an effective starting date of the first day of the first month after the date of transfer of records, but in no case will the OCDD or its agent "backdate" the PA
prior to the first day of the month in which the Transfer of Records Form was received by the OCDD or its agent. The transferring agency's PA will expire on the date of transfer of records.

Case Closure

The support coordination agency will submit the FORM 148 to the OCDD regional office and the local Medicaid office with the reason for closure noted. The PA will be modified to end on the date of closure. The OCDD or its agent will send the modified PA on the workday journal. The support coordination agency must edit/modify the PA in the CMIS software to reflect the modified PA.

Replacement Prior Authorizations

Replacement prior authorizations (PA) required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent to OCDD or its agent on the attached form. Requests will not be accepted over the telephone.

REPLACEMENT PA REQUEST FORM

Date of Request: ___/___/_____

Agency Name: _____

Agency Region: _____

Medicaid Provider Number: _____

Agency Telephone: _____

Agency Fax: _____

Recipient Name: _____
(Please Print)

Recipient SSN Number: _____-____-_____

Existing PA Number: _____

New Medicaid Number: _____

_____ _____
Signature of Requesting Party Date

Please mail request to:

Statistical Resources, Inc.
Support Coordination
11505 Perkins Rd., Suite H
Baton Rouge, LA 70810

IT IS NOT THE RESPONSIBILITY OF THE OCDD OR ITS AGENT TO VERIFY MEDICAID ELIGIBILITY OR TO DETERMINE IF THE RECIPIENT IS IN THE TARGET POPULATION. THIS IS THE PROVIDER'S RESPONSIBILITY.

Prior Authorization Checklist

PRIOR AUTHORIZATION CHECKLIST
(Please Print Information)

Agency Name: _____

Agency Region: _____

Recipient Name: _____

Recipient SSN: _____

Recipient DOB: _____

Recipient Medicaid #: _____
Must have **13-digit Medicaid number**, not the CCN Number

PROGRAM:

☐ **Louisiana Children's Choice Waiver (New Recipient)**
- ☐ CPOC Approval Page

Louisiana Children's Choice Waiver (Transfer Recipient)
- ☐ Freedom of Choice / Transfer of Records

☐ **MR/DD Waiver (New Recipient)**
- ☐ CPOC Approval Page

MR/DD Waiver (Transfer Recipient)
- ☐ Freedom of Choice / Transfer of Records

☐ **Infant and Toddler**
- ☐ Freedom of Choice / Transfer of Records
- ☐ CN 9 A & B
- ☐ CN 1
- ☐ IFSP Signature Page

☐ **Elderly and Disabled Adult Waiver (New Recipient)**
- ☐ CPOC Approval Page

Elderly and Disabled Adult Waiver (Transfer Recipient)
- ☐ Freedom of Choice / Transfer of Records

☐ **EPSDT - Target Population (New Recipient)**
- ☐ CPOC Approval Page

EPSDT - Target Population (Transfer Recipient)
- ○ Freedom of Choice / Transfer of Records

☐ **HIV**
- ☐ Freedom of Choice / Transfer of Records
- ☐ Approval Page of POC (Plan of Care)

Important Things to Remember

(a) Recipient Mailing Address:

Keep address current in the CMIS software. The CMIS data is used when mailing information to the recipients.

(b) Site Information:

Edit/Modify site information in the CMIS software whenever there is any change. This data is used for contacting agencies.

(c) PA Request:

PA's should be received within 7 days of sending the request to the OCDD or its agent. If no response has been received from the OCDD or its agent after 7 days, contact to the OCDD should be made.

(d) Checklist:

Use the checklist that will be attached to verify that all the forms necessary to obtain a PA number are enclosed. Packets will be returned if incomplete.

(e) Medicaid Numbers:

Verify the 13-digit Medicaid number for the recipient. Packets will be returned if incomplete.

(f) Data Submission:

Submit data at least weekly to the OCDD or its agent.

(g) Freedom of Choice Forms:

Under no circumstance will a PA be issued prior to the freedom of choice date.

Direct Service Providers Reimbursement

Louisiana Children's Choice Waiver direct services are billed on a CMS 1500 to the fiscal intermediary using procedure codes listed in Appendix A of this chapter. Instructions for billing are found in Chapter 7 (A).

Prior Authorizations for Direct Service Providers

The PA is issued based on the services approved on the CPOC/Revision. The PAs will begin on the CPOC begin date and will be issued for monthly intervals. For services that require a specified amount, the PA will not be released until the data is received.

PROGRAM MONITORING

Services offered through Louisiana Children's Choice Waiver are closely monitored to assure compliance with DHH policy as well as applicable state and federal regulations. The OCDD staff conducts on-site reviews of each provider agency contracted with DHH. These reviews are conducted to monitor the provider agency's compliance with DHH Provider Enrollment's 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.

Administrative records, personnel records, and a sample of recipient records are also reviewed as well as provider billing practices. In addition, provider agencies are monitored with respect to:

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

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

The OCDD Regional Office staff is available to answer questions regarding the interpretation of Louisiana Children's Choice Waiver policy. A provider's failure to follow DHH/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 are scheduled with the provider agency and conducted by OCDD Quality Management staff on a regular basis to

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

The OCDD Quality Management staff will utilize the "DHH Waiver Services Monitoring Report Form" during the on-site review and following the review to summarize review findings. The on-site review includes the components listed below.

Administrative Review

The Administrative Review includes:

- A review of administrative records,
- Other agency documentation, and
- Provider agency staff interviews to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the OCDD 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,
- Payroll records,
- Time sheets,
- Current organizational chart, and
- Provider agency staff interviews to ensure that support coordinators, direct service providers, and all supervisors meet the following staff qualifications:

  -Experience,
  -Skills,
  -Employment status,
  -Staff coverage
  -Supervisor-support coordinator ratio,
  -Caseload/recipient assignments,
  -Supervision documentation, and
  -Other applicable requirements.

Interviews

As part of the on-site review, the OCDD Quality Management staff will interview:

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

This interview process is to assess the overall satisfaction of recipients regarding the provider agency's performance, and to determine the presence of the personal outcomes defined and prioritized by the recipient/guardian. The process of interviewing people and determining the presence of personal outcomes will be in accordance with the recognized national standard model on outcome measures approved by the OCDD.

Recipient Record Review

Following the interviews described above, the OCDD Quality Management 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 CPOC), 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 CPOC,
- Provided,
- Documented properly,
- Appropriate in terms of frequency and intensity, and
- Relate back to personal outcomes on the CPOC.

The OCDD Quality Management staff will review the intake documentation of Louisiana Children's Choice 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. An abbreviated "DHH Waiver Services Monitoring Report Form" is completed on each record reviewed.

Quality Improvement Plan

The provider agency's approved continuous Quality Improvement Plan (QIP) 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.

- The quality improvement plan, any internal corrective action plans and documentation of QIP meetings of the provider agency are reviewed.
- Recipient input into service planning and timeliness of response to recipient requests are reviewed in the sampling of recipient records.
- The support coordination or direct service provider agency's involvement of recipient input in the improvement in quality of service provision is also reviewed.

Provider Self-Evaluation

The purpose of the self-evaluation is to assess the presence of personal outcomes, as defined and prioritized by the recipient/guardian, as well as the presence of required case record documentation in a representative sample of individuals served by each employee. The self-evaluation is also used for the agency to otherwise prepare for the on-site review by the OCDD Quality Management staff and representatives of DHH Research and Development Section. The self-evaluation must be based on the process for interviewing people and determining the presence of personal outcomes in accordance with the recognized national standard model on outcome measures approved by OCDD.

Components of the Provider Self-Evaluation

The self-evaluation must include:

- Interviews by the support coordination agency or direct service provider agency with the recipients in the representative sample,
- Interviews by the support coordination agency and direct service provider agency with others who know the individual best (family, friends, service and support providers, professionals, other members of the individual's network of support), and
- A review of the case records of the individuals in the representative sample.

Requirements of Self-Evaluation

Findings of the self-evaluation completed by the support coordination and direct service provider agency must indicate the presence of internal corrective action steps and progress to eliminate

the problem area(s). Case record documentation in this representative sample must adhere to the requirements indicated in *Record Keeping/Documentation, Covered Services,* and *Provider Requirements.* The self-evaluation must also indicate progress toward personal outcomes.

Report of Self-Evaluation Findings

The agency must submit four (4) copies of a report of the self-evaluation findings to the following address:

OCDD Waiver Supports and Services
446 N. 12th Street
Baton Rouge, LA 70802

The initial self-evaluation is completed six (6) months after approval of the initial plan and then once a year after the first report.

This report must include:

- A description of the personal outcomes defined and prioritized by each of the individuals in the representative sample;
- Assessment of the presence of required case record documentation in the representative sample;
- Written request or plan to acquire any needed technical assistance, training and/or support; and
- A sample of recipients included in the case record review is also surveyed to determine their satisfaction with the support coordination agencies and direct service providers. This part of the monitoring of the agency is to determine if the support coordination or direct service provider is generally meeting the needs of its recipients.

If the findings of the support coordination or direct service provider agency self-evaluation indicate that the agency is not working toward personal outcome requirements and/or case record documentation requirements, the self-evaluation report must also include a Quality Improvement Plan. This plan must describe how the agency will address issues with individual support coordinators or direct service staff to make systematic efforts to meet the personal outcome and case record documentation requirements.

Monitoring Report

Upon completion of the on-site review, the OCDD Quality Management staff discusses the preliminary findings of the review in an exit interview with appropriate staff of the support coordination or direct service provider agency. The OCDD Quality Management 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 within **15 working days of the on-site visit**.

The monitoring report includes:

- Identifying information,
- Specific strengths and deficiencies identified in the review, including the presence of personal outcomes in the representative sample of recipients interviewed by the OCDD Quality Management staff,
- Deficiencies requiring corrective action by the support coordination or direct service provider agency listed in order of severity in the report, and
- Recommended corrective action,

Although the monitoring report has an educational component, any inappropriate reimbursement for possible recoupment action is identified in the report.

The OCDD Quality Management staff will review the reports and assess any sanctions or liquidated damages as appropriate.

Corrective Action Report

The support coordination or direct service provider agency is required to submit a Plan of Correction (POC) to OCDD within **30 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 agency is afforded an opportunity to rebut the OCDD monitoring findings.

After the support coordination or direct service provider agency has had the opportunity to address the review findings, the OCDD Quality Management staff sends a memorandum to the Surveillance and Utilization Review System (SURS) Unit recommending a recoupment amount.

Upon receipt of the written Plan of Correction (POC), the OCDD Quality Management staff reviews the agency's plan within **90 days** to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the OCDD Quality Management staff responds to the provider requesting immediate resolution of those deficiencies in question.

A follow-up monitoring visit may be conducted when serious deficiencies have been found to ensure that the provider has fully implemented the plan of correction.

Mediation (Optional)

In the course of monitoring duties, an informal hearing process may be requested. The agency 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 agency and in no way limits the right of the

agency to a formal appeal hearing. In order to request the informal hearing, the agency should contact the Quality Management Administrator at

OCDD Waiver Supports and Services
ATTN.: Quality Management Section/Informal Discussion
446 N. 12th Street
Baton Rouge, LA 70802
(225) 219 - 0208

Every effort will be made to schedule a hearing at the convenience of the agency.

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

The agency is notified of time and place where the informal hearing will be held. The agency should bring all supporting documentation that is to be submitted for consideration.

The OCDD Quality Management Administrator solicits representation from other sections within the OCDD as well as other persons within BHSF to participate in the informal hearing process. The Quality Management Administrator should solicit between five to seven persons to participate.

When the informal hearing occurs, the Quality Management Administrator, who serves as the convener of the hearing, keeps the atmosphere informal. The agency is given the floor to present its case, to explain its disagreement with the monitoring findings, and/or to present new information. After the agency has explained its position, the agency representatives are asked to leave the hearing and are advised of the date that a written response will be sent. The agency is reminded of its right to a formal appeal.

The Quality Management Administrator engages the group in a discussion of the merits of the hearing. The Administrator moves for group consensus, and directs a member to record the panel's recommendations/decision that will be included in the written response. This written response is sent to the agency and may contain directions with time-lines for completion.

There is no appeal of the informal hearing decision; however, the agency may appeal the original findings to the DHH Bureau of Appeals. Should the agency not fulfill the panel's recommendations, the agency's licensing authority will be notified of a recommendation to not renew the agency's license.

APPENDIX A: CODES/RATES

CHILDREN'S CHOICE WAIVER
Waiver Eligibility Segment Code 00381

SERVICES PROCEDURE CODES/RATES
Effective April 1, 2004

All new HIPAA standard procedure codes listed below will be effective for dates of service April 1, 2004 and thereafter. Providers must bill the procedure code that is appropriate for the date of service on which services were rendered.

Provider Type	Local Code (effective prior to 4/1/04)	HCBS Waiver Service Description	HIPAA Code (effective 4/1/04)	MOD	HIPAA Service Description	Units
03	9E002	Crisis Support	H2011		Crisis Intervention	15 minutes $3.25
03	9E003	Family Support	S5125		Attendant Care Services	15 minutes $3.25
03	9E004	Center Based Respite	T1005	HQ	Respite Care	15 minutes $2.25
03	9E005	Family Training	S5111		Home Care Training-Family	Based on CPOC
03	9E006	Diapers	T2028		Specialized Supplies	
03	9E007	Ramp-Home	S5165	U4	Home Modifications	
03	9E008	Bathroom Modifications	S5165	U5	Home Modifications	
03	9E009	General Adaptations-Home	S5165		Home Modifications	
03	9E010	Vehicle Lifts	T2039		Vehicle Modifications	
	9E013	Crisis Support – 2 Children	H2011	UN	Crisis Intervention	15 minutes $2.44
03	9E014	Family Support – 2 Children	S5125	UN	Attendant Care Services	15 minutes $2.44
03	9E016	Crisis Support/Center Based	H2011	HQ	Crisis Intervention	15 minutes $2.44

Provider Type	Local Code (effective prior to 4/1/04)	HCBS Waiver Service Description	HIPAA Code (effective 4/1/04)	MOD	HIPAA Service Description	Units
45	9E001	Children's Choice Support coordination	9E001		Children's Choice Support coordination	Monthly $125.00

The specified modifier is required for this HIPAA code.

Modifiers: Certain procedure codes will require a modifier in order to distinguish services. The following modifiers are applicable to Children's Choice Waiver providers:

HQ = Group Setting

UN = 2 people

U4 = ramp, U5=bathroom

APPENDIX B: GLOSSARY

The following is a list of abbreviations, acronyms, and definitions used in the Louisiana Children's Choice Waiver Manual.

Agency

The legal entity enrolled to provide services under the approved Louisiana Children's Choice Waiver. Both public and private agencies are eligible to provide waiver services.

Appeal Rights

A due process system of procedures ensuring that a recipient or provider agency will be notified of and have an opportunity to contest certain decisions.

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.

Bureau of Health Services Financing (BHSF)

The Bureau within the Department of Health and Hospitals responsible for the administration of the Louisiana Medicaid Program.

Change of Ownership (CHOW)

Any change in the legal entity responsible for the operation of a provider agency.

Center for Medicare and Medicaid Services (CMS)

The Federal agency in DHHS responsible for administering the Medicaid Program and overseeing and monitoring the State's Medicaid Program.

CPOC

Comprehensive Plan of Care.

Department of Health and Hospitals (DHH)

The state department responsible for administering the Medicaid Program and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services.

Department of Health and Human Services (DHHS)

The federal agency responsible for administering the Medicaid Program and other public health programs.

Developmental Disability (DD)

Defined in La. R.S.28: 451.2. (R.S.28: 451.2 repeals the old R.S. 28:380-381).

- Meet the definition for a developmental disability as defined by The Developmental Disability Law, Louisiana Revised Statutes 28:451.1-455.2, which is as follows:

"A severe chronic disability of a person that:

(i) Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.
(ii) Is manifested before the person reaches age twenty-two.
(iii) Is likely to continue indefinitely.
(iv) Results in substantial functional limitations in three or more of the following areas of major life activity:
(aa) Self-care.
(bb) Receptive and expressive language.
(cc) Learning.
(dd) Mobility.
(ee) Self-direction.
(ff) Capacity for independent living.
(gg) Economic self-sufficiency.
(v) Is not attributable solely to mental illness.
(vi) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

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

(i) In addition to meeting the definition for a developmental disability, the individual must meet the requirements for an Intermediate Care Facility for the Mentally Retarded level of care, which requires active treatment of mental retardation or a developmental disability under the supervision of a qualified mental retardation or developmental disability professional.

Enrollment

The process of executing a contract with a potential provider for participation in the Medicaid program. Enrollment includes determination that a potential provider meets the requirements outlined in this document, the execution of a provider agreement, and assignment of the provider number used for payment

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.

Good Cause

Is defined as

- The recipient moves to a new region; or,
- The recipient and direct service provider agency have unresolved difficulties and mutually agree to a transfer; (This transfer must be approved by the OCDD support coordinator administrator); or,
- Safety, health, and welfare have been compromised and/or the direct service provider has not rendered satisfactory services to the recipient.

Home and Community-Based Services (HCBS)/Waiver

A Medicaid program established under Section 1915 (c) of the Social Security Act designed to provide services in a community setting to enable recipients who qualify for institutional care to remain in their own home setting. These services are administered by OCDD.

Licensure

A determination made by the Division of Licensing and Certification, Department of Social Services that a service provider meets the requirements of State law to provide services.

Medicaid/Medicaid Program

Medical assistance provided under the Louisiana Title XIX State Plan approved by the Center for Medicare and Medicaid Services under Title XIX of the Social Security Act, and under approved waivers of the provisions of that law.

Medicaid Management Information System (MMIS)

The computerized claims processing and information retrieval system for the Medicaid Program. The system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

Office for Citizens with Developmental Disabilities (OCDD) Waiver Supports & Services

The Bureau within the Department of Health and Hospitals that is responsible for administration of the Home and Community-Based Waiver services.

Person-Centered Assessment

The process of gathering and integrating formal and informal information relevant to the individual personal outcomes for the development of an individualized CPOC.

Person-Centered Planning Team

A team comprised of the recipient, recipient's family, support coordinator, direct service providers, medical and social work professionals as necessary, and advocates, who determine needed supports and services to meet the recipient's identified personal outcomes. For medical and social work professionals, participation may be by report.

Provider

Any individual or entity furnishing Medicaid services under a provider agreement with DHH.

Provider Agreement

A contract between the provider of services and the Bureau of Health Services Financing that specifies responsibilities with respect to the provision of services and payment under the Title XIX Medicaid Program.

Provider Enrollment

Another term for enrollment.

Reassessment

A core element of support coordination defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and redesigning the overall CPOC.

Recipient

Any individual who has been determined eligible for Medicaid, whether or not Medicaid reimbursement is made for services.

Slot

The number of openings available to be filled by eligible individuals for purposes of the waiver.

Support Coordination

Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational, and the other support services. This definition is adapted from P.L. 100-203 (g) (2) and Section 4302A of the *State Medicaid Manual.* Support coordination is a necessary component in

the management of services under this waiver, and provider agencies are licensed by OCDD.

Support Coordinator

An individual meeting the qualifications required by DHH who is employed by a qualified provider agency that provides support coordination services.

Title XIX

The section of the Social Security Act which is applicable to Medicaid services.

APPENDIX C

OCDD-PC-01-001	LOUISIANA CHILDREN=S CHOICE - FAMILY SUPPORT & EPSDT - PCS APPROVED SERVICES
OCDD-PC-01-002	LOUISIANA CHILDREN'S CHOICE - ENVIRONMENTAL MOD/VEHICLE LIFT FLOW CHART
OCDD-PF-01-006	ENVIRONMENTAL ACCESSABILITY ADAPTATIONS COMPLETION FORM AND INSTRUCTIONS
OCDD-RF-02-047WVR	RIGHTS AND RESPONSIBILITIES FOR APPLICANTS / RECIPIENTS OF HOME AND COMMUNITY-BASED WAIVER
OCDD Form AR	DOCUMENTATION FOR AUTHORIZED REPRESENTATION
OCDD Form RCAR	RECIPIENT'S CONSENT FOR AUTHORIZED REPRESENTATION
OCDD-IF-01-015	REQUEST FOR CRISIS DESIGNATION
OCDD-IC-01-012	REQUEST FOR CRISIS SUPPORTS FLOW CHART
OCDD-IF-01-014	REQUEST FOR NON-CRISIS DESIGNATION
OCDD-PF-01-007	REQUEST FOR FAMILY TRAINING/SUPPLEMENTAL FORM AND INSTRUCTIONS
OCDD-RC-01-003	COMPARISON CHART – CHILDREN'S CHOICE AND MR/DD WAIVER
OCDD-IC-01-015	OVERVIEW OF ENTRY PROCESS
OCDD-CPOC-CC	COMPREHENSIVE PLAN OF CARE AND INSTRUCTIONS

LOUISIANA CHILDREN=S CHOICE
FAMILY SUPPORT & EPSDT - PCS
Approved Services

Children=s Choice - Family Support		EPSDT - Personal Care Services (PCS)	
T	Can be provided without family present for all approved waiver recipients	T	Family must be present when services are provided unless the recipient is at least 14 years old **and** able to direct their own care
T	May administer medication if there is a Physician=s delegation or is a SCA	T	Shall not administer any medication
T	Must be prior authorized by OCDD	T	Must be prior authorized by BHSF/Unisys
T	Must be in an approved Comprehensive Plan of Care completed by Contract Support Coordination Agencies	T	Must be in a PCS agencies Plan of Care, have physician=s prescription and meet medical criteria that is submitted with request for prior authorization
T	Ages: Family Support (Children=s Choice) is for birth up to age 19	T	Ages: birth to 21
T	May transport or accompany recipient to medical appointments and other community outings as approved in the CPOC	T	May accompany recipients, but **DOES NOT TRANSPORT** recipients to medical appointments
T	Services include performing all services that a PCS can perform with the addition of medication administration, transporting to daily activities, providing services when the parent is not available.	T	Services include: basic personal care-toileting & grooming activities. Assistance with bladder and/or bowel requirements or problems. Assistance with eating and food preparation. Performance of incidental household chores, only for the recipient.

Louisiana Children=s Choice
Environmental Mod/Vehicle Lift

Step 1
Support Coordination

- If a need for an Environmental Mods/Vehicle Lifts is identified by the recipient, it is put on the CPOC at either the initial or through a CPOC revision
- At initial, the recipient should be asked if he/she knows anyone that can provide this service; if so put the person=s name as the sub-contract provider.

Step 2
Enrolled Provider

- Must coordinate a sub-contract provider if the recipient does not have someone in mind.
- Once sub-contract provider is identified, complete Section 1&2 of the Environmental Accessability Adaptations Form with copies to the sub-contract provider, recipient, and the Support Coordinator

Step 3
Support Coordination Agency

- If Environmental Mods/Vehicle Lifts was not identified in the initial CPOC, then a revision must be done and sent to the OCDD Regional Office for approval.
- If this service was identified on the CPOC without an associated cost or a sub-contract provider then a revision must be done to incorporate the missing information
- After approval from the OCDD, the CPOC Revision & Environmental Accessability Adaptations form must be sent to SRI for PA & a copy of the approved revision sent to the recipient and Enrolled Provider.

Step 4
Enrolled Provider

- Initiates the services approved
- Follow-up on the completion
- Section 3 shall be completed and sent to the Support Coordinator for follow-up
- Data on completion will be entered into reporting database and submitted - for release of the PA for payment

The Enrolled Provider is responsible for maintaining recipient fund availability within the waiver allocation year. The provider=s signature in Section 2 of the Environmental Accessability Adaptations Form is the provider=s statement that funds are available.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Office for Citizens with Developmental Disabilities
Louisiana Children=s Choice Waiver

Environmental Accessibility Adaptations Completion Form

SECTION 1	
Enrolled Provider Agency:	Phone #: ( ) -
Address:	Provider #:
Provider of Modification:	Phone #: ( ) -
Address:	
Recipient=s Name:	Medicaid ID #:
Address:	

SECTION 2 - Agreement Details	
Description of Approved Service:	
Procedure Code:	Approved Amount: $
Enrolled Agency Agreement:	Anticipated Completion Date:
Provider Agreement: Funds Available? 9 Yes	9 No
Recipient/Family Agreement:	

SECTION 3 - Documentation of Completion	
Description of Completed Job:	
Provider=s Signature:	Date Job Completed:
Enrolled Provider Signature:	
Does the Job Meet Applicable Building Code?	
Forward Completed form to the Support Coordinator for Prior Authorization	

SECTION 4 - Support Coordinator=s Verification of Completion	
Date Completed Job verified:	Job Acceptable?
Comments:	
Recipient/Family Acceptance Signature:	
Support Coordinator=s Signature:	

Environmental Accessibility Adaptations Completion Form

Instructions

This form is to be used for all vehicle lifts and home modifications in the approved CPOC. The Enrolled Service Provider is responsible for completing Sections 1, 2, & 3. The Support Coordinator is responsible for completing Section 4. All Approvals and Signatures must be in script and all other sections shall be printed.

Section 1:

After the CPOC is approved and the Family has agreed upon a provider for the service this demographic information shall be completed. The Enrolled Provider will ensure that the provider is aware of building codes. If it is a vehicle lift, then only vendors approved to install the equipment is appropriate.

Section 2:

Agreement Details shall be completed with all parties present (Enrolled Provider, recipient/family and provider of the service) and the recipient has final approval of the provider and the cost.

Description of Approved Service:	Print the Procedure Name
Procedure Code:	Print the Medicaid Procedure Code
Approved Amount:	The amount agreed upon by the recipient. The Enrolled Providers should assist the family with what would be a reasonable price.
Anticipated Completion Date:	Agreed upon date of completion
Enrolled Agency Agreement:	Presence of a signature of an agency representative indicates approval of the service, cost & completion date.
Funds Available:	this is the provider's approval there are funds
Provider Agreement:	Presence of a signature of a Provider representative indicates approval of the service, cost & completion date.
Recipient/Family Agreement:	Presence of a Parent/Guardian signature indicates approval of the provider, cost & completion date.

After Sections 1 & 2 have been completed, copies shall be given to the recipient and the selected provider. The Enrolled Provider must submit a copy to the Support Coordinator to complete a CPOC revision and to submit for OCDD Regional Office Approval. After approval the Support Coordinator will forward to SRI to Alock-in@ the estimated cost into the $6000 cap and a copy of the approval to the Enrolled Provider. If the Environmental Modification was identified in the initial CPOC and was approved, the Support Coordinator will submit a copy of this form with a copy of the approval page and Section IV.A. CPOC: Requested Waiver Services.

Section 3:

The selected provider will complete the following after the job is finished:

Description of Completed Job:	
Provider=s Signature:	Presence of a signature indicates the job has been completed as agreed upon
Date Job Completed:	Actual Date of Completion

The selected provider will then provide the form with their original signature to the Enrolled Provider who will then view the job with the family and complete the remainder of Section 3.

The Enrolled Provider will submit a copy of the form (with Sections 1 thru 3 completed) to the Support Coordinator for follow-up. The Enrolled Provider shall enter the data into the required system for PA.

Section 4:

The Support Coordinator shall complete this section upon the next face-to-face home visit but no more than six months after the job was completed. A copy of the completed form shall be sent to the OCDD Regional Office and to the Enrolled Provider. The copy with the Support Coordinator=s original signature will be kept in the recipient=s file at the Support Coordination Agency. The recipient will sign again to ensure they freely accepted the results.

Office for Citizen's with Developmental Disabilities

Rights and Responsibilities for Applicants / Recipients of a Home and Community Based Waiver

These are your **rights** as an applicant for or a recipient of a Home and Community-Based Waiver:

- To be treated with dignity and respect.
- To be free of abuse and neglect.
- To participate in and receive person-centered, individualized planning of supports and services.
- To receive accurate, complete, and timely information that includes a written explanation of the process of evaluation and participation in a Home and Community Based Waiver, including how you qualify for it and what to do if you are not satisfied.
- To work with competent, capable people in the system.
- To file a complaint, grievance, or appeal with a case management agency, direct service provider, or the Department of Health and Hospitals regarding services provided to you if you are dissatisfied. Please call our Help Line at 1-800-660-0488.
- To have a choice of service/support providers when there is a choice available.
- To receive services in a person-centered way from trained competent care givers.
- To have timely access to all approved services that are identified in your Comprehensive Plan of Care (CPOC).
- To receive in writing any rules, regulations, or other changes that affect your participation in a Home and Community Based Waiver.
- To receive information explaining case manager and direct service provider responsibilities and their requirements in providing services to you.
- To have all available Medicaid services explained to you and how to access them **if you are a Medicaid recipient.**

Office for Citizen's with Developmental Disabilities

Rights and Responsibilities for Applicants / Recipients of a Home and Community Based Waiver

Responsibilities as an applicant for or recipient of a Home and Community-Based Waiver continued:

- To actively participate in planning and making decisions on supports and services you need.
- To cooperate in planning for all the services and supports you will be receiving.
- To refuse to sign any paper that you do not understand or that is not complete.
- To provide all necessary information about yourself. This will help the case manager to develop a Comprehensive Plan of Care (CPOC) that will determine what services and supports you need.
- To not ask providers to do things in a way that are against the laws and procedures they are required to follow.
- To cooperate with the OCDD Staff and your case manager by allowing them to contact you by phone and visit you in your home at least quarterly. Necessary visits include pre-certification visits to assist the Regional Staff in providing the best services and supports possible, regular home visits to assure your plan of care is sufficient to meet your needs, visits resulting from complaints to OCDD, and visits needed to assure you are receiving the services as reported by your providers.
- To immediately notify the case manager and direct service provider who works with you if your health, medications, service needs, address, phone number, alternate contact number, or your financial situation changes.
- To help the case manager identify any natural and community supports that would be of assistance to you in meeting your needs.
- To follow the requirements of the program, and if information is not clear, ask the case manager or direct service provider to explain it to you.
- To verify you have received the waiver and medical services the provider says you have received, including the number of hours your direct care provider works, and report any differences to the OCDD Help Line at 1-800-660-0488.

Office for Citizen's with Developmental Disabilities

Rights and Responsibilities for Applicants / Recipients of a Home and Community Based Waiver

Responsibilities as an applicant for or recipient of a Home and Community-Based Waiver continued:

- To understand as a recipient of the waiver program, if you fail to receive waiver services for thirty (30) days or more your waiver case may be closed.
  - In the ADHC waiver, case management is not a separate service and the recipient must receive services at the ADHC facility.
  - In the NOW waiver, case management is not a waiver service and does not apply as a service in the thirty (30)-day rule.
  - The thirty (30)-day continuity of care rule does not apply to hospital days.

- To obtain BHSF Form 90-L (Request for Level of Care Determination) completed by your physician each year. Failure to provide this form at least 35 days prior to your annual CPOC may result in you becoming ineligible to receive further waiver services. Applicants and recipients for NOW and Children's Choice services must also provide a psychological assessment periodically as requested to continue to be eligible for services.

- To understand that all waiver programs have an age requirement and that you will not be offered services in a program that you previously requested if you no longer meet the age requirement for that program.

- To request different waiver services if you no longer meet any of the criteria as outlined on the waiver fact sheet that you received.

Office for Citizen's with Developmental Disabilities

Rights and Responsibilities for Applicants / Recipients of a Home and Community Based Waiver

I have read and understand my rights and responsibilities for applying for / participating in a Home and Community Based Waiver. I also understand the reasons that may cause me to lose these supports and services for me or the person whom I am authorized to represent in this matter.

- I understand as a recipient of the waiver program, if I fail to receive waiver services for thirty (30) days or more I may have my waiver case closed.
    - In the ADHC waiver, case management is not a separate service and I must receive services at the ADHC facility.
    - In the NOW waiver, case management is not a waiver service and does not apply as a service in the thirty (30)-day rule.
    - The thirty (30)-day continuity of care rule does not apply to hospital days.
- **As a Medicaid recipient**, I understand the Medicaid services available to me and how to receive them. (Medicaid recipients ONLY, please check the box.)

APPLICANT/RECIPIENT NAME:

Signature of Applicant/Recipient or Authorized Representative	Date
Case Manager	Date
OCDD Representative	Date

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Kathleen Babineaux Blanco
GOVERNOR

DOCUMENTATION FOR AUTHORIZED REPRESENTATION

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

Name of Applicant/Recipient _____ **SSN** _____ **ID#** _____

As the legally authorized representative of the above named recipient/applicant, I have provided proof to the Medicaid Program administrators in the form of one of the following documents:

1. **For Minors:**
   - 9 Non-parent must provide proof of authority to act (tutorship/custody) or statement such as the OCDD Form RCAR.
   - 9 Parent must show proof of parentage (child=s birth certificate and parent=s photo identification) and a signed affidavit stating they are not divorced from the other parent; or proof of custody; or authority to act

2. **For a Major or an Emancipated Minor:**
   - 9 Verify age (Birth Certificate or Photo ID)
   - 9 Emancipated minor must have judgment; marriage certificate

   Majors that wish to have an authorized representative must have:
   - 9 Signed Consent for Authorized Representation form (OCDD Form AR)

3. **Incompetent Major Recipient/Applicant must have the following:**
   - 9 Legal proof of Interdiction and proof of Appointment as Curator

I understand that all information gathered on the applicant/recipient=s situation is personal and confidential. I understand that my function as Authorized Representative is to accompany, assist, and represent the applicant/recipient in the eligibility determination process, and to aid in obtaining financial, medical and/or other documentation necessary for the agency=s determination of applicant/recipient/s initial or continuing eligibility for Medicaid.

_____ _____
Authorized Representative Date

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA DEPARTMENTOF
HEALTH AND HOSPITALS

OFFICE FOR CITIZENS
WITH DEVELOPMENTAL DISABILITIES

LOUISIANA
Department of
HEALTH and
HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

RECIPIENT'S CONSENT FOR AUTHORIZED REPRESENTATION

Name of Applicant/Recipient **SSN** **ID#**

I understand that all information gathered on my situation and those persons for whom I am legally responsible is personal and confidential. My decision to appoint an Authorized Representative is optional, made freely and does not relieve me of my responsibility to actively participate in the Medicaid eligibility process. I understand that the function of the Authorized Representative is to accompany, assist, and represent me in the eligibility determination process, and to aid in obtaining financial, medical and/or other documentation necessary for the agency=s determination of my initial or continuing eligibility for Medicaid. I also understand that my authorized representative has the power to make decisions for me concerning all aspects of various waiver programs administered by the Department of Health and Hospitals (DHH). I understand this may require the Department to disclose information to the representative named below that may otherwise be confidential. I hereby waive any rights I may have to prevent disclosure by the Department to the authorized representative named below.

I understand that this authorization is limited solely to the individual(s) named below and is valid until revoked by me. I further understand that I may cancel my appointment of the individuals(s) named below as my Authorized Representative(s) at any time upon written notice to the Department.

I understand that while some of the information gathered may have no impact on my Medicaid eligibility, it may affect my liability to a third party should this information be disclosed to the third party by my Authorized Representative. I hereby hold the Department of Health and Hospitals harmless for any claim resulting from disclosure of information to a third party by my Authorized Representative.

I understand that if this authorization is not signed in the presence of agency staff or a program representative, a confirmation of authenticity may be conducted by agency staff.

Name of Applicant/Recipient **SSN** **ID#**

Authorized Representative 1:

Authorized Representative Name: _____

Phone number: Home: _____ Work: _____

Address: _____

Authorized Representative 2:

Authorized Representative Name: _____

Phone number: Home: _____ Work: _____

Address: _____

Signature of Applicant/Recipient: _____

Date: _____

If signed with an AX,@ witness signature: _____

Date : _____

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

REQUEST FOR CRISIS DESIGNATION

SECTION I: Information

Name of Recipient:_____ DOB:_____

SSN:_____ Medicaid #:

Date of Family Request:_____ Date of PCP Meeting: _____ Region:_____

Support Coordinator:_____Agency:_____

Check one: G First Request G Extension 1 G Extension 2 G Extension 3

Is this an extension request? ☐ YES ☐ NO
Did the family request the child=s name be re-added to the MR/DD Waiver Request for Services Registry? ☐ YES ☐ NO

SECTION II: Reason for Request

Crisis designation is requested because (*check appropriate box and complete SECTION III*):

G Death of care giver with no other supports (i.e., other family) available. Date:_____

G Care giver incapacitated with no other supports (i.e., other family) available. *(Describe in Section 3 #1 below)* Date: _____

G Child is committed by court to DHH. (*Provide appropriate documentation.*) Date:_____

G Other family crisis with no care giver support available, such as abuse/neglect, or a second person in the household becomes disabled and must be cared for by same care giver, causing inability of the natural care giver to continue necessary supports to assure health and welfare. Date:_____

G Recipient=s condition has deteriorated to the point the plan of care is inadequate. Date:_____

Required Documentation

G CPOC REVISION ATTACHED
G RESOURCE EXPLORATION DOCUMENTATION ATTACHED
G FINANCIAL ASSISTANCE SUMMARY (State/Federally funded supports) ATTACHED
G NC-SNAP*
G HEALTH RISK SCREENING TOOL IF APPROPRIATE*

SECTION III: Description of Family Situation

DESCRIBE:

1. Nature of the crisis: *(Describe the circumstances leading up to and after the crisis - put the date of the crisis)*

*To be completed by OCDD when applicable

2. What additional supports are recommended to maintain the child in the home?

3. Identify attempts that have been made to provide supports: (*Family, friends, Support Coordinator, contact with OCDD, services that have been accessed, etc...use separate sheet if necessary)*

4. When is a permanent resolution of the crisis expected? (*Time frames*)

5. Request: (*Identify waiver supports and number of hours requested, use separate sheet if necessary)*

SECTION IV: OCDD Office Recommendation

Documentation supports request & identified situation: G Yes G No Crisis Designation: G Yes G No
Balance of children=s Choice Waiver funds available for remaining CPOC year $_____
Based on the information provided, I am requesting consideration of _____ *(#)* hours of crisis intervention per _____ *(day, week, etc.)* beginning _____ *(date)* and ending _____ *(date).*

Note: Maximum duration of initial crisis intervention period is three months.
Maximum duration of all periods of crisis intervention is one year.

Signature of OCDD Representative: _____

Date of referral to OCDD State Office: _____ Date Certified for Children=s Choice: _____

SECTION V: OCDD State Office Decision

Crisis Designation: * G Disapproved
G *Approved for _____ *(#)* hours of crisis intervention per _____ *(day, week, etc.)* beginning _____ *(date)* and ending _____ *(date).*

G Re-adding child to Request for Services Registry *(complete only if requested)*:
G Disapproved G Approved

Signature of OCDD State Office Representative: _____

Title: _____ Date: _____

* Additional Documentation for approval/disapproval attached G Yes G No

Form requires 48-hour (2 business days) turnaround from date of receipt by OCDD.

Instructions for OCDD-IF-01-015
Request for Crisis Designation

Families must choose to either accept Children=s Choice services or remain on the MR/DD Waiver Request for Services Registry. This is an individual decision based on a family=s current circumstances. A family who chooses Children=s Choice may later experience a crisis that increases the need for paid supports to a level that cannot be accommodated rendering the natural and community support system unable to provide for the health and welfare of the child at the level of benefits offered under Children=s Choice. The Crisis Designation has been developed to address these situations.

The family contacts the Support Coordinator who convenes the person-centered planning team to develop a plan for addressing the change in needs and completing the Crisis Designation Form if necessary.

Section I: Information

All demographics and information to be completed by the Recipient/Guardian and the Support Coordinator

Section II: Reason for Request

All information to be completed by the Recipient/Guardian and the Support Coordinator

Section III: Description of Family Situation

All information to be completed by the Recipient/Guardian, the Support Coordinator and OCDD Waiver Specialist/Representative

1. **Nature of the crisis:** List the date and circumstances leading up to and after the crisis.

   Families request to be re-added to the MR/DD Request For Services Registry: Only when the crisis designation (i.e. situation meets crisis designation requirements) is extended at the end of the initial duration (or at any time thereafter), the family may request the option of returning the child=s name to the original request date on the MR/DD Request for Services Registry when it is determined that the loss of care giver and lack of natural or community supports will be long-term or permanent. OCDD State Office will make this final determination. Eligibility and services through Children=s Choice shall continue as long as the child meets eligibility criteria.

2. **What additional supports are recommended to maintain the child in the home? *(Family, friends, Support Coordinator, contact with OCDD, services that have been accessed)*:** - In this section there shall be noted all attempts to obtain other natural supports, OCDD State Funded Supports, additional EPSDT-PCS supports, etc. and make note of all that were secured on a separate sheet if necessary.

   The Support Coordinator is required to exhaust all possible natural and community supports and resources available to the child and family prior to submitting a Request for Crisis Designation to the OCDD Regional Office. Only after it has been determined that there are insufficient natural or community supports available, the Support Coordinator shall complete this form.

3. **When is a permanent resolution of the crisis expected?** ***(Time Frame and why that time frame is necessary)***

   Crisis designation is time limited, depending on the anticipated duration of the causative event. Each Request for Crisis Designation may be approved for a maximum of three (3) months initially, and for subsequent periods of up to three (3) months, not to exceed twelve (12) months total or up to the annual CPOC date.

4. **Recommendation** ***(Identify waiver supports and numbers of hours requested with appropriate documentation)*** The team shall assess and see what services they feel the child requires to stay in the home. Use separate sheet if necessary.

After Sections I, II, and III are completed, submit to the OCDD Regional Office

Section IV: OCDD Regional Office Recommendation

OCDD Regional Office Staff will review the material submitted, make their recommendation on the Crisis Designation, and complete a new NC-SNAP and/or HRST if necessary.

After completion, submit this to the OCDD State Office Crisis Team

Section V: OCDD State Office Decision

OCDD Crisis Team is convened for review and approval/disapproval of the request.

Final decision is returned to the Regional Office for distribution to Support Coordinator & Guardian.

OCDD Louisiana Children=s Choice Waiver
Crisis Supports

Step 1
Support Coordination

- ☐ If a major change in the family is identified that impacts the caregivers ability to provide support for the child the Support Coordinator is to hold a meeting with at least the recipient, enrolled direct service provider, OCDD personnel if needed, and any other possible supports/resources as identified by the recipient.
- ☐ The meeting shall evaluate all current and needed supports for the health and welfare of the child (ie. EPSDT-PCS, home health, families, friends, OCDD state funded services).
- ☐ The Support Coordinator shall request intervention by the OCDD Regional HSCS/Waiver Specialist.
- ☐ If the supports identified at the meeting are not enough, then the Request for Crisis Designation shall be initiated as outlined in the manual
- ☐ A CPOC revision and the Request for Crisis Designation Form with supporting documentation shall be completed. The revision shall also identify the required additional Children=s Choice services that are required
- ☐ Send all documents to the OCDD Regional Office for review.

Step 2
OCDD Regional Office

- ☐ Upon receipt of request from support coordinator, OCDD Regional Office will immediately review the Request for Crisis Designation and CPOC revision.
- ☐ A NC-Snap will be completed and if indicated, a HRST will be completed.
- ☐ OCDD Regional Office will complete Section IV of the form with recommendation and shall forward all information to OCDD State Office MR/DD Waiver Program Manager for final designation.

Step 3
OCDD State Office/Regional Office

- ☐ OCDD State Office will review packet and make final decision, complete Section V of the Request form and notify OCDD Regional Office
- ☐ OCDD Regional Office will immediately notify the Support Coordinator of decision.

Step 4
Support Coordination Agency

- ☐ Notifies the recipient and enrolled provider of the approval and forwards copies of the approved CPOC revision and the Crisis Designation Form
- ☐ Sends the approved CPOC revision to SRI

Step 5
Enrolled Provider

- ☐ Initiates the services approved and as requested by the recipient
- ☐ Submits the required data in to the data collection system for prior authorization

Step 6
Support Coordinator

- ☐ Approvals are for up to a 3 month maximum. An assessment must be made prior to the expiration of the current approval
- ☐ If the situation has not resolved, initiate a request for an extension of Crisis Designation by submitting a new Request for Crisis Designation Form and new CPOC revision.
- ☐ Total time period of all designations shall not exceed 12 months or the annual CPOC date, whichever comes first.
- ☐ After the end of the plan year, the $7500 services allocation will be available to the child if the child remains eligible.

OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

REQUEST FOR NON-CRISIS DESIGNATION

SECTION I: Information

Name of Recipient:_____ **DOB:**_____

SSN:_____ **Medicaid #:**

Date of Request:_____ **Region:**_____

Support coordinator:
Agency:_____

Wait List Date on Request for Services Registry: _____

SECTION II: Non-Crisis/Other Good Cause Criteria Met

Non-Crisis designation meets all four criteria:

G **a. Benefits from services based on significant changes from baseline OCDD assessments, that are available in the MR/DD Waiver, which are not actually available to him or her through Children=s Choice waiver or through Medicaid; AND**

G **b. Would qualify for those services, based on significant changes from baseline OCDD assessments, under the standards applied in granting and denying the services to the MR/DD Waiver=s participants; AND**

G **c. There has been a change in circumstances, based on significant changes from baseline OCDD assessments, since his or her enrollment in the Children=s Choice Waiver causing these other services to be appropriate. This does not require that there has been a change in the recipient=s medical condition, but can include loss of in-home assistance through a caretaker=s decision to take on or increase employment, or to obtain education or training for employment. Vacations outside the continental U.S. are not considered Agood cause@; AND**

G **d. The person=s request date for the MR/DD Waiver has been passed on the Request for Services Registry.**

SECTION III: Description of Family Situation

DESCRIBE:

1. Nature of non-crisis/other good cause:

2. What additional supports are recommended that are not available in Children=s Choice?

3. What is the significant baseline change?

4. Recommendation: (*Identify waiver supports and number of hours needed.*)

SECTION IV: OCDD Regional Office Recommendation

Non-Crisis Designation:

G Yes G No Approved

G NC SNAP Completed on _____

G HRST Completed on _____

Signature of OCDD Regional Representative: _____

Date of referral to OCDD State Office: _____

NOTE: CPOC REVISION MUST BE SUBMITTED WITH REQUEST FOR NON-CRISIS APPROVAL

SECTION V: OCDD State Office Decision

Non-Crisis Designation for: _____ (*name of child*)

Decision for Non-Crisis Designation to re-adding child to waiting list:

G Disapproved G Approved

Signature of OCDD State Office Representative: _____

Title: _____ Date: _____

Instructions for OCDD-IF-01-014
Request For Non-Crisis Designation

Section I: Information

All demographics and information is to be completed by the recipient/guardian and the support coordinator.

Section II: All Four Non-Crisis/Other Good Cause Criteria Met

All information is to be completed by the recipient/Guardian and the support coordinator

Section III: Describe the Family Situation

This section is to be completed by the support coordination agency

Section IV: OCDD Regional Office Recommendations

OCDD regional office staff will complete the required assessment and submit it to the OCDD state office.

Section V: State Office Decision

OCDD crisis team is convened for review and approval/disapproval of the request. The final decision is returned to the regional office for distribution to the support coordinator and guardian.

Louisiana=s Children=s Choice
Request for Family Training Instructions

All travel shall be reimbursed at the actual amount of the receipts, not to exceed the maximum amounts allowed per the Louisiana Travel Regulations outlined for state employees (not special officials). The enrolled provider is required to **prepay the registration** for approved training. It is recommended that checks are made payable and submitted to the sponsor/organization providing the training. Other approved expenses shall only be reimbursed after the trip and with required documentation.

SECTION 1:
This section is to be completed with the enrolled provider and the family.
Attendee: The individual approved to attend the training and for whom the expenses will be paid.
Relationship: The relationship between the attendee and the family (i.e., parent, spouse, children, relatives, foster family, legal guardian, or in-laws).

Note: For each additional person approved to attend the same training, the provider must complete the Request For Family Training-Supplemental Form, @ Sections 1 and 2.

SECTION 2 - Explanation of Travel
Brochures/flyers etc. explaining the training and trainers must be attached to the request. All blocks in this section must be completed.

SECTION 3 - Reimbursement Requested
All reimbursement must be approved by DHH/OCDD prior to the begin date of travel and only those expenses that were requested and approved will be reimbursed. Receipts must be submitted for reimbursement. Please refer to the Louisiana State Travel Regulations outlined for State Employees. The Regulations are available on the Louisiana website (www.state.la.us). The Travel Regulations are under the Administration heading.

SECTION 4 - Agreements
Provider Signature: A representative from the Enrolled Provider shall sign indicating that the agency agrees with the data based on the information received from the recipient. The provider shall also explain to the recipient that if approved, the Total Amount of Request will be deducted from their remaining waiver allocation.

Recipient/Parent Signature: The parent shall sign indicating they agree with the data and understand that if approved, the Total Amount of Request will be deducted from the recipient=s remaining waiver allocation.

Participant=s Agreement to Attend Training: The person attending training shall sign indicating he/she agrees to attend and participate in the training for use in the care of the recipient.

SECTION 5 - DHH Decision
To be used by DHH/OCDD for Approval/Disapproval.

LOUISIANA CHILDREN=S CHOICE
REQUEST FOR FAMILY TRAINING

SECTION 1		SECTION 2 - Explanation of Travel	
Enrolled Provider:	Provider #:	Name of Training:	
Recipient Name:	MID#:	Place of Training (City/State):	
Attendee:	Relationship:	Sponsor of Training:	Travel Begin Date:
Address:	Phone #:		Travel End Date:
City/State/ZIP:	Paid Caregiver? GYes GNo	Credentials of Trainer:	

SECTION 3 - Reimbursement Requested			
G Registration Fee (brochure must be attached)		Amount $	Purpose of Training:
G Meals	# of Meals:	Amount $	
G Lodging	# of Nights: Cost/Night $	Amount $	
G Mileage	Est. Mileage	Amount $	
G Other Travel Expenses (describe):		Amount $	Explain how training will benefit the recipient as well as the caregiver: (use attachment if necessary):
Total Amount of Request:		$	

SECTION 4 - Agreements	SECTION 5 - DHH Decision		
Provider Signature Date	G Approved	G Approved with noted changes	G Disapproved
Recipient/Parent Signature Date	Comments:		
Participant=s Agreement to attend training Date	DHH Review Committee Member Date		

Issued: November 1, 2001

OCDD-PF-01-007

LOUISIANA CHILDREN=S CHOICE
REQUEST FOR FAMILY TRAINING - SUPPLEMENTAL FORM

SECTION 1 - Identifying Information		SECTION 1 - Identifying Information	
Enrolled Provider:	**Provider #:**	**Enrolled Provider:**	**Provider #:**
Recipient Name:	**MID#:**	**Recipient Name:**	**MID#:**
Attendee:	**Relationship:**	**Attendee:**	**Relationship:**
Address:	**Phone #:**	**Address:**	**Phone #:**
City/State/ZIP:	**Paid Caregiver?** G**Yes** G**No**	**City/State/ZIP:**	**Paid Caregiver?** G**Yes** G**No**

SECTION 2 - Reimbursement Requested			SECTION 2 - Reimbursement Requested		
G Registration Fee (brochure must be attached)		Amount $	G Registration Fee (brochure must be attached)		Amount $
G Meals	# of Meals:	Amount $	G Meals	# of Meals:	Amount $
G Lodging	# of Nights: Cost/Night $	Amount $	G Lodging	# of Nights: Cost/Night $	Amount $
G Mileage	Est. Mileage	Amount $	G Mileage	Est. Mileage	Amount $
G Other Travel Expenses (describe):		Amount $	G Other Travel Expenses (describe):		Amount $
Total Amount of Request:		**$**	**Total Amount of Request:**		**$**

Comparison Chart - Between Children's Choice and The New Opportunities Waiver (NOW)

Issue	NOW	Children's Choice
Eligibility, General Provisions		
Age	No age limit	Birth through age 18; at 19 will transition into an available, appropriate waiver
Disability	Disabled according to SSI definition	Same
Level of Care	Qualifies medically for ICF/MR institutional level of care (meets state definition of developmental disability)	Same
Income/ Resources	Income < 3X SSI amount, Parents income counted for first month only, Resources < $2,000	Same
Other	U.S. citizen or authorized alien, resident of Louisiana, has S.S. #	Same
How to Apply	Contact your local Office for Citizen's with Developmental Disabilities (OCDD), see attached sheet.	Same
Medicaid Services	Medically appropriate services covered under the Medicaid State Plan, including EPSDT services for recipients. Some limits apply for adults.	All medically appropriate services covered under the Medicaid State Plan, including EPSDT services.
Service Limits	Services as approved on the Plan of Care with no cap on total waiver expenditures. Some services have service limits or dollar maximums.	Services as approved on the Plan of Care subject to a $15,000 cap per CPOC year. $1,500 of the waiver allowance is reserved for mandatory case management.
Waiver Services		
Care giver Assistance	Individual and Family Support Services; also EPSDT Personal Care Services	Waiver Family Support; also EPSDT Personal Care Services
Skilled Nursing	Provided as a waiver service; also EPSDT Extended Home Health	Not provided for in the Children's Choice Waiver. Children can access through Medicaid State Plan EPSDT Extended Home Health.
Center-Based Respite	Provides out-of-home temporary care (720 hours per year) of individuals who are unable to care for themselves when the primary care giver is absent or in need of relief.	Same
Specialized Medical Equipment and	Adaptive aides which enable individuals to increase their abilities to perform tasks of daily living (3 year dormancy period between	Not provided for in the Children's Choice Waiver. Adaptive aides may be available for children under the Medicaid EPSDT

Supplies	$4000 caps)	services.
Environment Accessibility Adaptations	Adaptations to home or vehicle to make it more accessible (3 year dormancy period between $4000 caps)	Same, no limit other than waiver cap
Case Management	Required to assist with planning and accessing services. Provided as a Medicaid service. Not a waiver service.	Required waiver service provided with $1,500 of the $15,000 waiver cap to assist with planning and accessing services.
Family Training	Not provided	Training and education for families to help understand and meet the needs of their child
Crisis Support	In the event of a crisis, the plan of care would be amended to add Individual and Family Support or Center Based Respite, EPSDT Personal Care Services, and/or Extended Home Health to meet the health and welfare needs of the child.	In the event of a crisis, and after meeting crisis criteria, the plan of care would be amended to add necessary EPSDT Personal Care Services, Extended Home Health and/or Crisis Support (waiver service not subject to the $15,000 limit) to meet the health and welfare needs of the child.
Diapers	Not provided	Provided for recipient over 3 when necessary
Professional Services/ Consultation	Professional Services Professional Consultation	Not provided for in the Children's Choice Waiver. Available through Medicaid EPSDT services.
Other Services	Day Habilitation Personal Emergency Response Supervised Independent Living Supported Employment Substitute Family Care Employment Related Training Community Integration Development Transitional Professional Support (for Individuals Transitioning from ICF/MR) Services One-Time Transitional Expenses (for Individuals transitioning from a ICF/MR)	Not provided for in the Children's Choice Waiver.

OCDD Louisiana Children=s Choice Waiver
Overview of Entry Process

Step 1
OCDD/Contractor (SRI)
- ☐ Recipient accepts Children=s Choice
- ☐ All yes responses sent to Birch & Davis

Step 2
Birch & Davis
- ☐ If no SOE, then ask guardian for a current 1508 **or** if SOE is questionable provide a current SOE of other psychological data
- ☐ Contact guardian to see if already SSI eligible and to complete a mini-social
- ☐ If recipient appears eligible, a 90-L is requested
- ☐ Inform of Kidmed & LaChip if applicable

Step 3
OCDD/Contractor (SRI)
- ☐ If MR/DD criteria not met, OCDD notifies individual by letter
- ☐ If MR/DD criteria met, a Support Coordination FOC is sent to recipient
- ☐ When FOC is received, linkage is made to appropriate Support Coordination Agency
- ☐ Eligibility documents mailed to Support Coordination Agency
- ☐ Recipient & OCDD notified of linkage

Step 4
Support Coordination Agency
- ☐ Receives FOC & linkage & eligibility documents
- ☐ Contacts recipient within three calendar days of notification of linkage
- ☐ Offers FOC of enrolled direct service provider
- ☐ Sets appointment with recipient & service provider to develop CPOC

Step 5
Support Coordination Agency
- ☐ CPOC finalized & signed by guardian, provider & others that attend the planning meeting
- ☐ Submits a complete CPOC packet to OCDD Regional Office within 35 calendar days of linkage
- ☐ Waiver application sent to BHSF Parish Office

Step 6
OCDD Regional Office
Receives CPOC Packet (returned if incomplete)
- ☐ Conducts pre-certification home visit
  Provides information on informed choice, completes Snap, completes HRST if necessary
- ☐ Issues notification of approval of CPOC via 142 to BHSF Parish Office, guardian & Support Coordination Agency

Step 7
BHSF Medicaid Parish Office
- ☐ Financial Eligibility determined
- ☐ 18LTC issued for approval or disapproval to guardian, Support Coordination Agency and OCDD

Step 8
Support Coordination Agency
- ☐ Sends copy of approved CPOC to provider & guardian
- ☐ Sends copy of the signature **AND** services page (page 11) of the CPOC to SRI for Prior Authorization (PA) & the 142

Step 9
OCDD/Contractor (SRI)
- ☐ PA numbers for Support Coordination Agency & Enrolled Provider sent to each agency
- ☐ PA released to Unisys after data is entered into system and submitted to SRI

Step 10
Enrolled Direct Service Provider Agency
- ☐ Implements the CPOC
- ☐ Meets with recipient/guardian to identify additional providers for services in the approved CPOC
- ☐ Submits appropriate data into Data Collection System prior to billing

Step 11
Support Coordination Agency
- ☐ Must have at a minimum, monthly telephone contacts with recipient and guardian
- ☐ A home visit must occur between the 6th & 9th month after approval of the CPOC, or more frequently at family=s request
- ☐ Annual CPOC completed and submitted to OCDD Regional Office no less than 35 calendar days prior to expiration

Louisiana Department of Health and Hospitals-Office for Citizen's with Developmental Disabilities
Comprehensive Plan of Care for Children's Choice Waiver

TYPE: ☐ INITIAL ☐ ANNUAL

PERSON'S NAME	DOB	LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER		RELATIONSHIP	
MEDICAID ID #		Is this a Legal Relationship as identified in Legal Status below?	
ADDRESS		ADDRESS (if different)	
CITY/STATE/ZIP	PARISH	CITY/STATE/ZIP	
DAYTIME PHONE	NIGHTTIME PHONE	DAYTIME PHONE	NIGHTTIME PHONE

CASE MANAGEMENT AGENCY	PROVIDER NUMBER
ADDRESS OF CASE MANAGEMENT	CONTACT PERSON (Case Manager)
CITY/STATE/ZIP	TELEPHONE NUMBER

SEX: ☐ MALE ☐ FEMALE **RACE:** ☐ BLACK ☐ WHITE ☐ HISPANIC ☐ ASIAN ☐ OTHER: _____
EDUCATION: ☐ ATTENDS SCHOOL ☐ HOMEBOUND ☐ 9 MONTHS ☐10 MONTHS ☐N/A
LEGAL STATUS: ☐ MINOR ☐ INTERDICTED ☐ POWER OF ATTORNEY ☐ COMPETENT MAJOR ☐ OTHER: _____
MR: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER: _____
ADAPTIVE FUNCTIONING: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER: _____
90L: PHYSICIAN DATE:_____ CM REC'D_____ **AMBULATION:** ☐ YES ☐ NO
SELF-EVACUATE HOME: ☐ YES ☐ NO **IF NO, INDIVIDUALIZED EVACUATION PLAN IS ATTACHED:** ☐ YES ☐ NO
EMERGENCY RESPONSE LEVEL: ☐ LEVEL 1Total Assistance with Life Sustaining equipment ☐ LEVEL 2 Total Assistance
☐ LEVEL 3 Can respond/Needs transportation ☐ LEVEL 4 Can respond independently

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? ☐ YES ☐ NO IF YES, WHERE?_____
PROPOSED LIVING ADDRESS:_____
ARE THERE MULTIPLE WAIVER RECIPIENTS IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY?_____
ARE THERE MULTIPLE INDIVIDUALS WITH MR/DD (not a recipient) IN THE HOME? ☐ YES ☐ NO IF YES, HOW MANY___
DOES THE CPOC INCLUDE PLANS FOR RESTRAINTS? ☐ YES ☐ NO
ARE PAID CAREGIVERS RELATED TO RECIPIENT? ☐ YES ☐NO IF YES, RELATION & SERVICE_____
_____
DO PAID CAREGIVERS LIVE WITH RECIPIENT? ☐ YES ☐ NO IF YES, NAME & SERVICE_____
_____

PRESENT HOUSING ARRANGEMENT:
☐ ICF/MR ☐ NURSING FACILITY
☐ OWN HOME (Parent/Guardian): ☐ OTHER'S HOME:
IF ELIGIBLE, DID THE RECIPIENT RECEIVE AN OFFER TO CHANGE DIRECT SERVICE PROVIDERS? ☐ YES ☐ NO
WAS A CHANGE IN DIRECT SERVICE PROVIDER REQUESTED? ☐ YES ☐ NO
WAS A FREEDOM OF CHOICE OFFERED? ☐ YES ☐ NO

FOR OCDD USE ONLY: HIGH RISK RECIPIENT: ☐ YES ☐ NO (If Yes, OCDD will add to High Risk Tracking)
Final Packet Receipt Date:

SECTION I: EMERGENCY INFORMATION

Recipient Name:	Age:

Address:

Directions to home:

Persons responsible for evacuating, if necessary, or bring supplies to recipient's home:

Name:	Relationship:
Address:	
Home Phone:	Work/Other Phone:

Family members/others to contact in case of emergency:

Name:	Relationship:
Address:	
Home Phone:	Work/Other Phone:
Name:	Relationship:
Address:	
Home Phone:	Work/Other Phone:

Emergency equipment in home:(fire extinguishers, smoke detectors, first aid kits, home evacuation plan, specialized medical equipment)

Special Consideration: (assistive technology supporting independence, ventilator dependent, medications, etc.)

Agencies involved with recipient: (Service Providers, OCS, APS, LRS, churches, etc.)	
Agency:	Phone:
Contact Person:	
Agency:	Phone:
Contact Person:	
Agency:	Phone:
Contact Person:	

Recipient's Physicians:

Doctor's Name	Specialty	Phone

SECTION II: CURRENT STATUS OF THE INDIVIDUAL'S PERSONAL OUTCOMES AND SUPPORTS

1. IDENTITY: People choose personal goals; People choose where & with whom they live; People choose where they work; People have intimate relationships; People are satisfied with services; People are satisfied with their personal situations.
Current Status: Supports:
2. AUTONOMY: People choose their routine; People have time, space & opportunity for privacy; People decide when to share personal information; People use their environment.
Current status: Supports:
3. AFFILIATION: People live in integrated environments; People participate in the life of the community; People interact with other members of the community; People perform different social roles; People have friends; People are respected.
Current status: Supports:
4. ATTAINMENT: People choose services; People realize personal goals.
Current Status: Supports:

SECTION II: CURRENT STATUS OF THE INDIVIDUAL'S PERSONAL OUTCOMES AND SUPPORTS (CONTINUED)

5. SAFEGUARDS: People are connected to natural support networks; People are safe.
Current Status: Supports:
6. RIGHTS: People exercise rights; People are treated fairly.
Current Status: Supports:
7. HEALTH AND WELLNESS: People have the best possible health; People are free from abuse and neglect; People experience continuity and security.
Current Status: Supports:

SECTION III: HEALTH PROFILE

A. HEALTH STATUS

1. PHYSICAL:

2. MEDICAL DIAGNOSES/CONCERNS/SIGNIFICANT MEDICAL HISTORY:

3. PSYCHIATRIC/BEHAVIORAL CONCERNS:

4. BEHAVIOR PLAN ENCLOSED (if needed): ☐ YES ☐ NO

5. INCIDENT REPORTS (for past 6 months): **SUMMARY:**

A. Incidents #_____
B. Non-critical Incidents #_____
C. Hospital Admissions #_____
D. Emergency Visits_____
E. Psych Hospital Admissions #_____

B. TREATMENTS: (catherization, tube feeding, dressing changes, splints, braces, suction, etc.)

C. ALLERGIES:

Medications: _____ Food: _____ Airborne: _____

What does the reaction look like, or what occurs with the reaction? **(BE SPECIFIC)**

SECTION IV: HEALTH PROFILE - CONTINUED

D. MEDICATIONS/ MEDICAL PROCEDURES	DOSAGE	WHAT IS IT FOR?	HOW IS IT TAKEN? ROUTE	WHEN IS IT TAKEN? FREQUENCY	TO BE ADMINISTERED BY: (self, family, staff, CMA, CNA, etc.)

Note: Attach additional page if more space is needed.

PHYSICIAN DELEGATION NEEDED: ☐ YES (attach to CPOC if needed) ☐ NO

SECTION V: RECIPIENT PROFILE

A. PERTINENT HISTORICAL INFORMATION: Date, age at time of onset and cause of disability. If not known, enter "unknown". Placement history; recurring situations that impact care; response to interventions in the past; summary of events leading to request for service at this time.)

B. PRESENT: DESCRIBE CURRENT LIVING SITUATION: (Describe current family situation; level of education attainment; identify family's understanding of individual's situation/condition, knowledge of disability and consequences of non-compliance with CPOC; economic status; relevant social environment and health factors that impact individual (i.e., health of care givers, home in rural/urban area, accessibly to resources); own home/rental/living with relatives/extended family or single family dwelling. Is the home environmentally safe? Does the home environment adequately meet the needs of individual or will environmental modifications be required?)

C. NATURAL SUPPORTS: (List family members, names and ages; how they are involved/not involved; Who is the primary care giver (PCG)? Is the PCG employed? Are any of the care givers paid for supports? If there are no natural supports, has guardianship been considered? Description of complete social support network-list friends and other community resources involved in supporting the individual on a daily basis.)

D. COMMUNITY SUPPORTS/OTHER AGENCY INVOLVEMENT: (Individual's significant life events, which may include family issues, issues with social/law enforcement agencies. Does individual have social services caseworker or Probation Officer assigned? Will you have to interact with that agency/individual?)

E. DESCRIBE DAILY LIVING SKILLS:

Information included on this page is relevant to the individual's life today and provides a means of sharing social/family history not addressed in the content of the CPOC. Include information that the person and/or their family feels is important to share and relevant to supporting and achieving the outcomes determined by the person.

SECTION VI. PERSONAL PREFERENCES

GIFTS AND TALENTS:	THINGS THAT WORK: LIKES/NEGOTIABLE	THINGS THAT DON'T WORK: DISLIKES/NON-NEGOTIABLE

SECTION VII. CPOC SERVICES, NEEDS AND SUPPORTS

Utilize this form to complete the Case Management and provider plan of care. Reference each Service Area. This form may be duplicated as necessary.

SERVICES:

CASE MANAGEMENT
RAMP-HOME
FAMILY SUPPORT / 2 CHILDREN
ACTIVITIES (ex. Games, crafts, reading)
CRISIS SUPPORT
BATHROOM MODS
FAMILY SUPPORT
GENERAL ADAPTATIONS - HOME
CRISIS SUPPORT/ CENTER BASED
OTHER RESOURCES (SPECIFY)
CENTER BASED RESPITE
VEHICLE LIFTS
FAMILY /VOLUNTEER
FAMILY TRAINING
CRISIS SUPPORT / 2 CHILDREN
NON-MEDICAID RESOURCES
DIAPERS

PERSONAL OUTCOMES "What" the individual wants for his/her self	**SUPPORT STRATEGY NEEDED** "What" is needed to achieve the Personal Outcome? "How will the support be delivered? "Who" will deliver the support? (paid/unpaid support) "Where" will the support be provided? "Will" assistive devices be required? Be specific	**HOW OFTEN FOR SUPPORTS AND SERVICES** List the service/support and "How often" they will be provided?	**REVIEW / RESOLUTION DATE** "When" will the support be reviewed/the Personal Outcome be achieved?
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	4.
4.	4.	4.	5.

Note: Planning must include and reflect emergency back-up plans for services and emergencies.

SECTION VIII: CPOC TYPICAL WEEKLY SCHEDULE (Planning Worksheet)

FOR PLANNING PURPOSES ONLY. IF MY NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE. I HAVE INCLUDED ALL THE PCS, STATE PLAN, HOME HEALTH, RESPITE AND OTHER SERVICES I PLAN TO USE.

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
12:00 AM							
01:00 AM							
02:00 AM							
03:00 AM							
04:00 AM							
05:00 AM							
06:00 AM							
07:00 AM							
08:00 AM							
09:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
01:00 PM							
02:00 PM							
03:00 PM							
04:00 PM							
05:00 PM							
06:00 PM							
07:00 PM							
08:00 PM							
09:00 PM							
10:00 PM							
11:00 PM							

COMMENTS:

SECTION IX: CPOC REQUESTED WAIVER SERVICES

List the recipient's requested services as described in the CPOC.

Name:_____ Program Type: Children's Choice CPOC Begin Date: _____ CPOC End Date:_____

1.	2.	3.	4.	5.	6.	7.	8.	9.
Provider's Full Name	**Provider #**	**Service type**	**Procedure Code**	**Monthly**	**# of Units (Not hours)**	**Cost per Unit**	**Yearly costs[1]**	**Admin fees[2] (diapers, etc)**
		Case Management	**9E001**	**$125.00**	**12**		**$1500.00**	
		Family Support	**9E003**		**Not to Exceed**	**$6.50**		

Please check your math. Total cost of all combined services[1] and administrative fees[2] cannot exceed $15,000 per CPOC year.	**Grand Total**	

Case Manager's Signature Date Individual/Guardian Date

Children's Choice Provider signature of agreement to deliver above services and understanding that services cannot begin or be reimbursed until PA is issued. _____ Date: _____

OCDD APPROVAL:_____ Region :_____ Date:_____Received: _____

SECTION X: CPOC PARTICIPANTS

Participants must sign indicating they participated in the planning meeting & agree with the plan.

PLANNING PARTICIPANTS	TITLE

I have reviewed the services contained in this plan. I choose to accept this plan and the services described. I understand it is my responsibility to notify the case manager of any change in my status, which might affect the effectiveness of this program. I further agree to notify the case manager of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.

I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion with OCDD and/or a fair hearing by the DHH Appeals Bureau within 10 days of the approved/denied decision and/or contact my OCDD Regional Office for an informal discussion. I understand that a DHH Appeals Bureau Fair Hearing may be requested by contacting the DHH Bureau of Appeals, P.O. Box 4183, Baton Rouge, LA. 70821-0165.

_____ _____

Person's Signature/Guardian Signature Date

_____ _____

Witness/Professional Title/Agency Date

_____ _____

CASE MANAGER SUPERVISOR'S SIGNATURE DATE

SECTION XI: CARE PLAN ACTION

Recipient Name:_____

DATE COMPLETE CPOC RECEIVED IN OCDD Regional Office:_____

This CPOC meets the identified needs of the individual: ☐ APPROVED ☐ DENIED

Without the services available through this waiver, the recipient would qualify for institutional care: ☐ YES ☐ NO

APPROVED CPOC BEGIN DATE :_____ APPROVED CPOC END DATE:

_____

SERVICES APPROVED:

Signature/Title of OCDD
Representative:_____ Date:_____

INSTRUCTIONS FOR THE CPOC REVISION REQUEST

The CPOC Revision Request is designed to document any revision(s) to the original, OCDD APPROVED CPOC. Only the recipient and/or family/guardian can make a request to the case manager for a revision to be made to the services currently delivered. The case manager will then contact the service provider to begin the process of working out the details of the request, staffing, hours, etc, and is responsible for submitting the request. The Office for Citizens with Developmental Disabilities (OCDD) Regional Office must approve the request before implementation of changes can occur. **Revision requests never change the beginning or ending dates of the current care plan.**

Documents, such as, medical reports, prescriptions, evaluations, letters, etc, should be attached to the requested revision to support the justification. If needed, the OCDD Regional Office will request a new schedule page to accompany the revision request.

Revision #: Enter the revision number here. Example; Revision #1, Revision #2, etc.

Recipient Name: Enter the name of the Recipient.

Medicaid #: Enter the Medicaid number.

CPOC Begin Date: Enter the CPOC begin Date.

CPOC End Date: Enter CPOC end date.

Case Management Agency: Enter the full name of the case management agency that is submitting the revision.

Phone #: Enter the phone number in which the case manager may be contacted should further clarifications be necessary.

Type of Revision; Routine or Emergency: Enter by checking or marking an "x" in the space provided, whether the revision request is a routine request or an emergency request.

Date Revision Request Submitted to OCDD: Enter the date.

Date of Recipient Request: Enter the date the recipient notified the case manager of the need for the revision.

Revision for: Enter the reason for the revision here.

Column 1, Provider's Full Name: Spell it out. Do not use initials.

Column 2, Provider's Number: Enter the correct numbers in this column.

Please refer to Section 11 of the Children's Choice manual for the following:

Column 3, Service Type: Enter the type of support.

Column 4, Procedure Code: Enter the type of code.

Column 5, Monthly Charge: Enter the monthly charge.

Column 6, # of Units Not hours: Enter the number of units, not hours.

Column 7, Cost per Units: Enter the cost per unit.

Column 8, Yearly Costs: Every service will have a yearly cost. For simplicity, the cost of case management is already included in the format. It is $1,500. The number of units, times the cost per units will give you a yearly cost for the other services.

Column 9, Admin. Fees: Some services have an administrative fee. Enter the Amount of the Administrative fee for the support.

Column 10, Requested Start Date: When do you want the services to begin? Must allow at least a seven day turn around time from the OCDD-RO.

Column 11, End Date: Unless this is a service that will be completed in a short amount of time such as a home mod, the End date will be the CPOC end date.

Indicate all yearly totals and the Grand Total for all services.

Signature of the case manager, the date the request is signed.

Signature of the Children's Choice Provider and the date the request is signed is necessary in this section.

Signature of the OCDD-RO and the date the request is signed is necessary in this section.

This last line is to be filled out by the OCDD-RO for review and appropriate determination. Once approved or denied, the representative will mail a copy of the OCDD-CC-Revision to the appropriate case manager. Original request will be kept in the recipient's file.

Please review the Sample CPOC Revision sheet and the instructions that accompany it.

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS [illegible]ICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
CHILDREN'S CHOICE COMPREHENSIVE PLAN OF CARE REVISION REQUEST

Revision #_____
Recipient Name_____ Medicaid#_____ CPOC Begin Date:_____ CPOC End Date:
C.M. Agency:_____ Phone #:
Type of Revision: ☐ Routine ☐ Emergency Date Revision request Submitted to OCDD:_____ Date of Recipient Request:

Revision For:

1	2	3	4	5	6	7	8	9	10	11
Provider's Full Name	Provider #	Service Type	Procedure Code	Monthly	# of Units Not Hours	Cost per Unit	Yearly Cost[1]	Admin fees[2] (Diapers, etc)	Requested Start Date	End Date
		Case Management	9E001	$125.00	12		$1500.00			
		Family Support	9E003			$6.50				
						yearly totals ☞			☜ yearly totals	
Please check your math. Total cost of all combined services[1] and Admin fees[2] cannot exceed $15,000 per CPOC year.									Grand Total	

Case Manager's Signature: _____ Date: _____ Individual/Guardian:_____ Date:
Childrens' Choice Provider Signature of Agreement to Deliver Above Listed Services and understanding that services cannot begin or be reimbursed until PA is issued.
_____ Date: _____

BCSS Signature:_____ Received:_____ Approved: _____ Denied:_____ Effective:_____
This CPOC budget sheet supersedes all previously OCDD approved budget sheets issued for this recipient from the initial, through and up to this approved dated request. The CPOC Service Balance Report must be attached and include a family estimate of services to be used up to the requested start date of the revised services.

INSTRUCTIONS FOR THE CPOC REVISION REQUEST

The CPOC Revision Request is designed to document any revision(s) to the original, OCDD APPROVED CPOC. Only the recipient and/or family/guardian can make a request to the case manager for a revision to be made to the services currently delivered. The case manager will then contact the service provider to begin the process of working out the details of the request, staffing, hours, etc, and is responsible for submitting the request. The Office for Citizens with Developmental Disabilities (OCDD) Regional Office must approve the request before implementation of changes can occur. **Revision requests never change the beginning or ending dates of the current care plan.**

Documents, such as, medical reports, prescriptions, evaluations, letters, etc, should be attached to the requested revision to support the justification. If needed, the OCDD Regional Office will request a new schedule page to accompany the revision request.

Revision #: Enter the revision number here. Example; Revision #1, Revision #2, etc.

Recipient Name: Enter the name of the Recipient.

Medicaid #: Enter the Medicaid number.

CPOC Begin Date: Enter the CPOC begin Date.

CPOC End Date: Enter CPOC end date.

Case Management Agency: Enter the full name of the case management agency that is submitting the revision.

Phone #: Enter the phone number in which the case manager may be contacted should further clarifications be necessary.

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Column 1, Provider's Full Name: Spell it out. Do not use initials.

Column 2, Provider's Number: Enter the correct numbers in this column.

Please refer to Section 11 of the Children's Choice manual for the following:

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Column 4, Procedure Code: Enter the type of code.

Column 5, Monthly Charge: Enter the monthly charge.

Column 6, # of Units Not hours: Enter the number of units, not hours.

Column 7, Cost per Units: Enter the cost per unit.

Column 8, Yearly Costs: Every service will have a yearly cost. For simplicity, the cost of case management is already included in the format. It is $1,500. The number of units, times the cost per units will give you a yearly cost for the other services.

Column 9, Admin. Fees: Some services have an administrative fee. Enter the Amount of the Administrative fee for the support.

Column 10, Requested Start Date: When do you want the services to begin? Must allow at least a seven day turn around time from the OCDD-RO.

Column 11, End Date: Unless this is a service that will be completed in a short amount of time such as a home mod, the End date will be the CPOC end date.

Indicate all yearly totals and the Grand Total for all services.

Signature of the case manager, the date the request is signed.

Signature of the Children's Choice Provider and the date the request is signed is necessary in this section.

Signature of the OCDD-RO and the date the request is signed is necessary in this section.

This last line is to be filled out by the OCDD-RO for review and appropriate determination. Once approved or denied, the representative will mail a copy of the OCDD-CC-Revision to the appropriate case manager. Original request will be kept in the recipient's file.

Please review the Sample CPOC Revision sheet and the instructions that accompany it.

KIDMED, a program of Louisiana Medicaid starts an eligible Medicaid recipient under 21 years of age on a healthy life by offering preventative care, like regular examinations and immunizations. Regular examinations may prevent future problems and immunizations will protect your child from diseases like measles and mumps. If you are a Medicaid recipient under the age of 21, you may be eligible for the following services at no cost to you:

Doctor visits; hospital (inpatient and outpatient) services; lab test and x-ray; family planning services; home health care; dental care; rehabilitation services; prescription drugs; medical equipment, appliances and supplies (DME); case management; speech and language evaluations and therapies; occupational therapy; physical therapy; psychological evaluations and therapy; psychological and behavior services; podiatry services; optometrist services; hospice services; extended home health services; residential institutional care; home and community based (waiver) services; medical, dental, vision and hearing screenings, both periodic and interperiodic; immunizations; eyeglasses; hearing aids; psychiatric hospital care; personal care services; audiological services; necessary transportation: Ambulance transportation, non-ambulance transportation; appointment scheduling assistance; chiropractic services; prenatal care; certified nurse midwives; certified nurse practitioners; mental health rehabilitation; mental health clinic services; addictive disorder services and any other medically necessary health care, diagnostic services, treatment, and other measures which are coverable by Medicaid, which includes a wide range of services not covered for recipients over the age of 21.

For further information regarding available services, or to schedule necessary transportation for your children or yourself (if under 21 years of age), you may contact **KIDMED** by calling **1-877-455-9955**. To schedule a screening visit, you may contact KIDMED at 1-800-259-4444 (or 928-9683 if you live in the Baton Rouge area), or by contacting your physician if you already have a KIDMED provider. If you are deaf or hard of hearing, please call the TTY number, 1-877-544-9544. If you have a communication disability or are non-English speaking, you may have someone call KIDMED and the appropriate assistance can be provided.

Some of these services must be approved by Medicaid in advance. Your medical provider should be aware of which services must be pre-approved and can assist you in obtaining those services. Also, KIDMED can assist you or your medical provider with information as to which services must be pre-approved.

Louisiana Medicaid encourages you to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

CLAIMS FILING

TABLE OF CONTENTS

HARD COPY CLAIMS PROCESSING

The CMS-1500 is to be used when filing paper claims. These forms can be obtained through most business form vendors, some office supply stores, or by sending a letter of order request and a check to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Phone (202) 512-1800

All Louisiana Medicaid paper claims are now scanned and stored online. This process allows the fiscal intermediary Provider Relations Department to respond more efficiently to claim inquiries by facilitating the retrieval and research of submitted claims.

If you cannot submit claims electronically, prepare your paper claim forms according to the following instructions to ensure appropriate and timely processing.

- Submit an original claim form whenever possible. Do not submit carbon copies under any circumstances. If you must submit a photocopy, ensure that it is legible, and not too light or too dark.
- Enter information within the appropriate boxes and align forms in your printer to ensure the correct horizontal and vertical placement of data elements within the appropriate boxes.
- Use high quality printer ribbons and cartridges – black ink only.
- We recommend using the font types Courier 12, Arial 11, or Times New Roman and font sizes 10-12.
- Do not use italic, bold, or underline features.
- Do not submit two-sided documents.
- Do not use a marking pen to omit claim line entries. Use a black ballpoint pen (medium point).

Attachment Size

All claim attachments should be standard 8 ½ X 11 sheets. Any attachments larger or smaller than this size should be copied onto standard sized paper.

Highlighting Specific Information

Providers who want to draw attention of a reviewer to a specific part of a report or attachment are asked to circle that particular paragraph or sentence. Do not use highlighters on claim forms.

ELECTRONIC CLAIMS PROCESSING

Providers are strongly encouraged to file claims using the Electronic Media Claims (EMC) process via the computer. With electronic media, a provider or a third party contractor (vendor, billing agent or clearinghouse) submits Medicaid claims to the fiscal intermediary on a computer encoded magnetic tape, diskette, or via telecommunications (modem). A list of vendors, billing agents and clearinghouses (VBCs) that can provide electronic billing services is available through the fiscal intermediary.

Each claim undergoes the editing common to all claims, e.g., verification of dates and balancing. Each type of claim has unique edits consistent with the requirements outlined in the provider manuals. All claims received via electronic media must satisfy the criteria listed in the manual for that type of claim.

Advantages of submitting claims electronically include increased cash flow, improved claim control, decrease in time for receipt of payment, automation of receivables information, improved claim reporting by observation of errors and reduction of errors through pre-editing claims information.

Each tape, diskette or telecommunicated file submitted for processing must be accompanied by a submission certification form signed by the authorized Medicaid provider or billing agent for each provider whose claims are billed using electronic media. The certification must be included in each tape or diskette submitted. Providers submitting by telecommunications must submit this certification within 48 hours.

Providers who need copies of the certification forms should call the EMC Department at Unisys and request an EMC packet. The packet includes the different types of certification forms required. Third-party billers are also required to submit a certification form. Providers should select the certification form in the packet that applies to their particular provider type and make copies as necessary for submission to Unisys.
To contact the EMC Department at Unisys, call (225) 237-3200 and select option 2.
Providers may write to:

Unisys EMC Department
P.O. Box 91025
Baton Rouge, LA 70821

Electronic Media Claims (EMC) may be submitted by magnetic tape, 5 1/4" diskette, 3 1/2" diskette, or telecommunication (modem). Submission deadlines for regular business hours follow. These deadlines may change to accommodate holiday schedules.

Magnetic Tape and Diskettes	4:30 P.M. each Wednesday
Telecommunications (Modem)	10:00 A.M. each Thursday
KIDMED Submissions (All Media)	4:30 P.M. each Wednesday

Changes to Claim Forms

It has always been Louisiana Medicaid policy that the fiscal intermediary staff is not allowed to change any information on a provider's claim form. We want to remind providers of this policy and use this avenue to again inform you that if changes are required on a claim before it can be resubmitted, you must make those changes and resubmit the claim. Please do not ask the fiscal intermediary staff to make any changes on your behalf.

Data Entry

Data entry clerks do not make any attempt to interpret the claim form – they merely enter the data as found on the form. If the data is incorrect, or IS NOT IN THE CORRECT LOCATION, the claim will not process correctly.

General Reminders

- Do not forget to sign and date your claim form. The fiscal intermediary will accept stamped or computer-generated signatures, but authorized personnel must initial them.
- Continuous feed forms must be torn apart before submission.
- Claims with attachments cannot be billed electronically
- The recipient's 13-digit Medicaid ID number must be used to bill claims. The 16-digit CCN number from the plastic ID card is **NOT** acceptable.

Claims Documentation

The Louisiana Medicaid program is required to make payment decisions based on the information submitted on the claim.

CMS-1500 CLAIM FORM AND BILLING INSTRUCTIONS

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

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

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

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

SIGNED

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Instructions For Completing The CMS-1500 Claim Form

Items to be completed are either required or situational. Required information must be entered in order for the claim to process. If items marked with an asterisk "*" are not completed, the claim will be denied. Claims submitted with missing or invalid information in certain key fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. Situational information may be required but only in certain circumstances as detailed in the instructions below.

1. Enter an "X" in the box marked Medicaid (Medicaid #).

1A.* **Insured's ID Number**—Enter the recipient's 13-digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card (MEVS) or through REVS.

NOTE: The recipients' 13-digit Medicaid ID number **must** be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable.

Note: If the 13-digit Medicaid ID number does not match the recipient's name in block 2, the claims will be denied. If this item is blank, the claim will be returned.

2.* **Patient's Name**—Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as it appears on the recipient's plastic Medicaid card or as verified through the Medicaid recipient eligibility verification systems.

3. **Patient's Birth Date and Sex**—Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.

4. **Insured's Name**—Complete correctly if appropriate or leave this space blank.

5. **Patient's Address**—Print the recipient's permanent address.

6. **Patient Relationship to Insured**—Complete if appropriate or leave this space blank.

7. **Insured's Address**—Complete if appropriate or leave this space blank.

8. **Patient Status**—Leave this space blank.

9. **Other Insured's Name**—Complete if appropriate or leave this space blank.

Insured's Policy or Population Number—Complete using the recipient's 6-digit TPL carrier code if the recipient has other insurance and the claims has been processed by the third party insurer. (If this is the case, the EOB from the other insurance should be attached to the claim.) If the recipient does not have other coverage, leave this space blank.

9B. **Other Insured's Date of Birth**—Complete if appropriate or leave this space blank.

9C. **Employer's Name or School Name**—Complete if appropriate or leave this space blank.

9D. **Insurance Plan Name or Program Name**—Complete if appropriate or leave this space blank.

10. **Was Condition Related To**—Leave this space blank.

11. **Insured Policy Group or FECA Number**—Complete if appropriate or leave this space blank.

11A. **Insured's Date of Birth**—Complete if appropriate or leave this space blank.

11B. **Employer's Name of School Name**—Complete if appropriate or leave this space blank.

11C. **Insurance Plan Name or Program Name**—Complete if appropriate or leave this space blank.

12. **Patient's or Authorized Person's Signature**—Complete if appropriate or leave this space blank.

13. **Insured's or Authorized Person's Signature**—Obtain signature if appropriate or leave this space blank.

14. **Date of Current Illness**—Leave this space blank.

15. **Date of Same or Similar Illness**—Leave this space blank.

16. **Dates Patient Unable to Work**—Leave this space blank.

17. **Name of Ref erring Physician or Other Source**—If services are performed by a CRNA, the name of the directing physician must be entered here. If services are performed by an independent laboratory, the name of the referring physician must be entered in this field. If services are performed by a nurse practitioner or clinical nurse specialist, the name of the directing physician must be entered in this field. If the recipient is a lock-in recipient and has been referred to the billing provider for service, the lock-in physician's name must be entered here.

17a **ID Number of Referring Physician**—Enter the referring physician's Medicaid ID number, if known. If the recipient is a CommunityCARE recipient, the PCP's referral authorization number must be entered here.

18. **Hospitalization Dates Related to Current Services**—Leave this space blank.

19. **Reserved for Local Use**—Leave this space blank.

20. **Outside Lab**—Leave this space blank.

21.* **Diagnosis or Nature of Illness or Injury**—Enter the numeric code and literal description. Use of ICD-9-CM coding is mandatory. Accepted abbreviations are appropriate.

22. **Medical Resubmission Code**—Leave this space blank.

23.* **Prior Authorization**—Complete if appropriate or leave space blank.

24A.* **Date of Service**—Enter the date the service for each procedure billed using six (6) digits (MM DD YY). If "from" and "to" dates are shown here for a series of identical procedures on the same day or on consecutive days, enter the number of services in item 24G. The date of dissemination may be used for evaluation services.

24B.* **Place of Service**—Enter the appropriate code. These codes and descriptions are maintained at posinfo@cms.hhs.gov and may also be obtained from the fiscal intermediary

24C. **Type of Service**—Leave this space blank.

24D.* **Procedure Code**—Enter the appropriate encounter code on the first line.

24E.* **Diagnosis Code**—Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a **"1, 2, 3, or 4."** More than one diagnosis may be related to a procedure. Do not enter an ICD-9-CM diagnosis code in this item.

24F.* **Charges**—Enter your usual and customary charges for this procedure.

24G.* **Days or Units**—Enter the number of the same procedure being billed for the same date of service.

24H. **EPSDT**—Enter a "Y".

24I. **EMG**—Leave this space blank.

24J. **COB**—Leave this space blank.

24K. **Reserved for Local Use**—Enter the attending provider number if applicable.

25. **Federal Tax ID Number**—Leave this space blank.

26. **Your Patient's Account Number**—(Optional) Enter the recipient's medical record number or other individual provider assigned number to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of sixteen (16) characters.

27. **Accepts Assignment**—Leave this space blank. Medicaid does not make payments to the recipient. Claim filing shows acceptance of Medicaid assignment.

28.* **Total Charge**—Total of all charges listed on the claim.

29. **Amount Paid**—Complete if appropriate. Leave this space blank for EPSDT.

30. **Balance Due**—Complete if appropriate. Leave this space blank for EPSDT.

31.* **Signature of Physician/Supplier**—The claim form **MUST** be signed. The therapist is not required to sign the claim form. However, the therapist's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the physician, therapist or authorized representative. **If this item is left blank, or if the stamped or computer-generated signature does not have original initials, the claim cannot be processed for payment.**

Date—Enter the date of the signature.

32. **Name and Address Where Services Were Rendered**—Leave this space blank.

33.* **Physician's or Medical Assistance Supplier's Name, Address, Zip Code and Telephone Number and PIN**—Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid provider number must be entered in the space next to "Group (Grp) #."

Note: If no Medicaid provider number is entered, the claim will be returned to the provider for correction and resubmission.

ADJUSTING OR VOIDING CLAIMS

Incorrect claims payments may be adjusted or voided either electronically or hard copy.

- Only a paid claim can be adjusted or voided.
- Incorrect provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided, and then resubmitted.
- Complete the information on the adjustment form exactly as it appears on the original claim, changing only that item or items that were in error and giving the reasons for the changes in the space provided.
- To void a paid claim, enter all of the information from the original claim **exactly** as it appears on the original claim. After a voided claim has appeared on the Remittance Advice (RA), an original claim can be resubmitted giving all of the correct information that should appear on that claim.
- It is important to enter the correct Internal Control Number and Remittance Advice date from the paid claims in blocks 26 and 27 on the adjustment/void form. If this information is not entered exactly, the claim will deny with error message 799 (no history for this adjustment/void).
- When an Adjustment/Void form has been processed it will appear on the RA under **Adjusted or Voided Claims**. The adjustment or void will appear first. The original claim line will appear in the section directly beneath under the heading **Previously Paid Claims**.
- An Adjustment/Void will generate credit and debit entries that will appear in the Remittance Summary on the last page of the RA as "Adjusted Claims," "Previously Paid Claims" **or** "Voided Claims."

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

The same requirements that apply to hard copy adjustments/voids apply to electronic adjustments/voids.

Hard Copy Adjustments and Voids

The 213 adjustment/void form is used for filing hard copy adjustments/voids. Completed Adjustment/Void forms should be mailed to the following address for processing:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

Only one (1) internal control number can be adjusted or voided on each 213 form.

213 Adjustment/Void Form Sample

MAIL TO:
UNISYS
P.O. BOX 91020
BATON ROUGE, LA 70821
(800) 473-2783
924-5013 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
3 PATIENT'S DATE OF BIRTH
4 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX MALE FEMALE
7 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
8 INSURED'S I.D., MEDICARE, AND/OR MEDICAID NO. (INCLUDE ANY LETTER)
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G. PUBLIC HEALTH AGENCY)
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR 4 IN CODE.
1
2
3
23 EPSDT FAMILY PLANNING YES NO YES NO
24 PRIOR AUTHORIZATION NO.

A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. I.D. QUAL.	H. LEAVE BLANK

25 CONTROL NUMBER
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
26 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

27 REASONS FOR ADJUSTMENT
- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 03 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY - RECOVERY
- ☐ 99 OTHER - PLEASE EXPLAIN

28 REASONS FOR VOID
- ☐ 10 CLAIM PAID FOR WRONG RECIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER - PLEASE EXPLAIN

29 SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
30 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE
31 YOUR PATIENT'S ACCOUNT NUMBER

FISCAL AGENT COPY

UNISYS-213
7/01

Instructions for Completing the 213 Adjustment/Void Form

1.* **ADJ/VOID**—Check the appropriate block.

2.* **Patient's Name**

- **Adjust**—Print the name exactly as it appears on the original claim if not adjusting this information.
- **Void**—Print the name exactly as it appears on the original claim.

3. **Patient's Date of Birth**

- **Adjust**—Print the date exactly as it appears on the original claim if not adjusting this information.
- **Void**—Print the name exactly as it appears on the original claim.

4. **Medicaid ID Number**—Enter the 13 digit recipient ID number.

5. **Patient's Address and Telephone Number**

- **Adjust**—Print the address exactly as it appears on the original claim.
- **Void**—Print the address exactly as it appears on the original claim.

6. **Patient's Sex**

- **Adjust**—Print this information exactly as it appears on the original claim if not adjusting this information.
- **Void**—Print this information exactly as it appears on the original claim.

7.* **Insured's Name**— Leave this space blank.

8. **Patient's Relationship to Insured**—Leave this space blank.

9. **Insured's Group No.**—Complete if appropriate or leave space blank.

10. **Other Health Insurance Coverage**—Leave this space blank.

11. **Was Condition Related to:**—Leave this space blank.

12. **Insured's Address**—Leave this space blank.

13. **Date of:**—Leave this space blank.

14. **Date First Consulted You for This Condition**—Leave this space blank.

15. **Has Patient ever had same or Similar Symptoms**—Leave this space blank.

16. **Date Patient Able to Return to Work**—Leave this space blank.

17. **Dates of Total Disability-Dates of Partial Disability**—Leave this space blank.

18. **Name of Referring Physician or Other Source**—Leave this space blank.

19. **For Services Related to Hospitalization Give Hospitalization Dates**—Leave this space blank.

20. **Name and Address of Facility Where Services Rendered (if other than home or office)**—Leave this space blank.

21. **Was Laboratory Work Performed Outside of Office?**—Leave this space blank.

22.* **Diagnosis of Nature of Illness**

- **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.
- **Void**—Print the information exactly as it appears on the original claim.

23. **Attending Number**—Enter the attending number submitted on original claim, if any or leave this space blank.

24.* **Prior Authorization #**—Enter the PA number if applicable or leave blank.

25.* **A through F**

- **To Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.
- **To Void**—Print the information exactly as it appears on the original claim.

26.* **Control Number**—Print the correct Control Number as shown on the Remittance Advice.

27.* **Date of Remittance Advice that Listed Claim was Paid**—Enter MM DD YY from RA form.

28.* **Reasons for Adjustment**—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.

29.* **Reasons for Void**—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.

30.* **Signature of Physician or Supplier**—All Adjustment/Void forms **must** be signed.

31.* **Physician's or Supplier's Name, Address, Zip Code and Telephone Number**—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. ***The form will be returned if this information is not entered.***

32.* **Patient's Account Number**—(Optional) Enter the patient's correct provider-assigned account number.

Marked (*) items must be completed or form will be returned.

WHAT HAPPENS TO YOUR CLAIM?

When your claim is received in the mailroom, addressed to the proper Post Office Box for the claim type, it will be edited for missing data. If the signature, recipient Medicaid identification number, service dates, or provider name and/or number is missing the claim is rejected and returned to the provider.

Returned Claims

If the invoice is rejected because of missing or incomplete items, the original invoice you submitted will be returned to you accompanied by a return letter. The return letter will indicate why the invoice has been returned to you. A returned claim will not appear on the RA because it will not have entered the claims processing system. In addition, it will not be microfilmed and given a unique 13-digit Internal Control Number (ICN) before being returned to you.

Claims which have all the necessary items for claims processing completed proceed to the next part of the claims processing cycle, in which the claim is microfilmed, given an internal control number and are entered into the computer for processing.

Processed Claims

Claims that enter the processing system will be either approved (paid), pended or denied.

All claims that have been processed will fall into one of these three categories. You will receive an RA for each payment cycle in which you have claims processed.

TIMELY FILING GUIDELINES

To be reimbursed for services rendered, all providers must comply with the following filing limits set by the Medicaid Program.

- Straight Medicaid claims filed on the CMS-1500 must be filed within 12 months of the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare Fiscal Intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulation.
- Claims for recipients covered by Medicare and Medicaid (dual eligibility) must be billed to Medicare within 12 months of the date of service.
- Claims which fail to cross over via tape and have to be filed hard copy must be filed within six months of the date on the Medicare Explanation of Benefits in order to meet Medicaid timely filing regulations.
- Most dual eligible claims will crossover to Medicaid via tape and do not need to be filed hardcopy with the fiscal intermediary.
- Claims with third-party liability (TPL) payment must be filed within 12 months of the date of service. After receipt of payment from the TPL, the Medicaid claim must be filed ***hardcopy with an Explanation of Benefits (EOB) attached.***
- Claims denied by Medicare as non-covered that are covered by Medicaid will not be paid unless the claim is filed hardcopy with the Medicare EOMB attached stating the reason for denial by Medicare.

Medicaid will not pay a claim which has been denied by Medicare as not being medically necessary.

- Claims for recipients with retroactive coverage, e.g., spend-down medically needy claims, should be sent to the fiscal intermediary with a note of explanation AND a copy of Form 18-SSI (Medicaid Program Notice of Decision) or other official documentation from DHH indicating the recipient's retroactive status as soon as possible. The mailing address is as follows:

Unisys
Provider Relations
P. O. Box 91024
Baton Rouge, LA 70821

All claims for recipients with retroactive Medicaid coverage will be forwarded to BHSF for review and authorization.

Filing For Claims Exceeding The Timely Filing Limit

Medicaid claims received after the one (1) year maximum timely filing date cannot be processed unless the provider is able to furnish documentation of timely filing. This documentation must be legible and reference the individual recipient and the date of service. It may include:

A remittance advice (RA) indicating that the claim was processed within the original appropriate time frame;

OR

Correspondence received from either the state or parish Bureau of Health Services Financing office concerning the claim and/or the eligibility of the recipient.

Providers should ensure that the claim submitted with documentation is legible so that should the documentation uphold the request for an override of timely filing, that the claim can be successfully adjudicated.

Exception Requests for Claims Beyond the Two Year Timely Filing Limit

Claims that exceed two years from the date of service must be sent to the Bureau for review. The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend benefits of a hearing decision, corrective action or court order to other in the same situation as those directly affected by it.

- The recipient was certified for retroactive Medicaid benefits and the provider has filed the original claim within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits.
- The failure of the claim to pay was the fault of the Medicaid Program rather than the provider's fault each time the claim was adjudicated.
- The documentation of retroactive eligibility or your attempts to resolve the billing problems must be attached to the claim.

Tips On Timely Filing For Providers

- Providers must know how to bill correctly and how to resolve billing problems.
- Because of timely filing limitations, providers must make the necessary claim corrections within the timely filing limits. Re-filing a claim several times without correcting previously cited errors IS NOT considered a valid attempt to resolve a billing problem.
- All required items on the claim must be completed correctly.

- Providers are notified of claims that are denied for payment by the RA. A three (3)-digit error code designating the error is printed for each claim. These codes are listed with a brief explanation being given for each one on the RA that is on a separate page following the status listing of all claims. If you do not understand the process, contact Provider Relations, and someone will assist you with the matter.
- **Providers must make their own corrections. It is against regulations for the fiscal intermediary and/or DHH staff to make claim corrections for a provider.**
- The fiscal intermediary offers consultation for providers having problems billing correctly and/or resolving billing problems. **Contact Provider Relations at 1-800-473-2783 or (225) 924-5040.**

THIRD-PARTY LIABILITY (TPL)

Medicaid, by law, is intended to be the payor of last resort. Therefore, other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid recipient. When Medicaid is billed, the third-party carrier's Explanation of Benefits must be attached to the claim form.

If probable third party liability is established at the time the claim is filed, Medicaid will deny the claim and return it to the provider for determination of third party liability for most Medicaid services. There will be a carrier code number and listing made available to providers by the fiscal intermediary so that a claim can be submitted to the carrier by the provider. Also available to assist the provider with identifying the third party carrier are the MEVS and REVS systems.

If you find that the information regarding third party coverage provided is erroneous, it will be necessary for you to write to Provider Relations with a copy of the correspondence from the third party carrier. The fiscal intermediary will forward that correspondence to the Bureau for correction of the file.

If the carrier adjudicates the claim, then the provider must attach the EOB to a claim and resubmit the claim to the fiscal intermediary. If the carrier deems there is no coverage available then that claim and explanation should be sent to Provider Relations for file resolution, as stated above, prior to payment.

For recipients with Medicare coverage as well as Medicaid coverage, Medicaid will reimburse the provider an amount up to the full amount of the Medicare's statement of liability for co-insurance and deductible as long as it does not exceed Medicaid's allowable reimbursement for the service. Claims for which Medicare's reimbursement exceeds the maximum allowable by Medicaid, Medicaid will then "zero" pay the claim. This means that the claim will be shown in the Approved Claims section of the Remittance Advice and a "0" will be shown in the payment column. This claim is considered "payment in full" and the provider may not seek additional remuneration from the recipient.

MEDICARE/MEDICAID CROSSOVER PROCEDURES

Medicaid will pay the Medicare deductible and coinsurance on claims for non-QMB (Qualified Medicare Beneficiary) beneficiaries receiving both Medicare and Medicaid, provided the procedure is covered by the Louisiana Medicaid Program. For QMB beneficiaries, the Medicare deductible and coinsurance are paid even if the procedure is not in "pay" status.

If a patient has both Medicare and Medicaid coverage, providers should file claims in the appropriate manner with the regional Medicare Fiscal Intermediary/carrier, making sure they have included the beneficiary's Medicaid number on the Medicare claim form.

Once the Medicare intermediary/carrier has processed the Medicare portion of the core visit, the provider must send a hard copy claim to Unisys for co-insurance and deductible payment. To process hard copy Medicare crossover claims, the provider must do the following:

- Make a copy of the claim filed to Medicare
- Put the Medicaid provider number and recipient Medicaid number in the appropriate form locators
- Attach the Medicare EOB to the claim

The provide may submit a copy of the Medicare EOB providing the copy is legible. In addition, all of the EOB data, such as patient name and dates of service must match.

Medicare crossover claim should be sent to the following address for processing:

Unisys
P.O. Box 91023
Baton Rouge, LA 70821

Once a claim is received, the claim will be processed, and reimbursement for the deductible and coinsurance amounts will be made to the provider. Provider should receive the Medicaid payment four to six weeks after receiving the Medicare payment.

If a provider's Medicare/Medicaid claim does not appear on a Remittance Advice within six weeks of the Medicare date of pay, the claim has failed to crossover electronically and must be filed hardcopy.

THE REMITTANCE ADVICE

The purpose of the section is to familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the BHSF, and the fiscal intermediary. Aside from providing a record of transactions, the RA will assist providers in resolving and correcting possible errors and recording paid claims.

The Purpose Of The Remittance Advice

The RA is the control document that informs the provider of the current status of submitted claims – approved, pended, or denied. RAs are generated weekly for all providers who have claims processed during that weekly cycle and are mailed on Tuesdays of each week.

On the line immediately below each claim, a code will be printed representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. Approved original claims will not be accompanied by denial reason codes.

If you use a medical record number, (it may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

Approved Claims

Claims which are correctly completed when billing for a covered service provided to an eligible recipient/patient by an enrolled provider will be approved for payment and reimbursement will be made. It will appear on the RA on the first page or the page that lists all claims to be paid on the RA. If the payment is different from the billed charges, an explanation will appear on the RA via a 3-digit error code and an error message for that code will be found at the back of the RA.

Denied Claims

A claim will be denied for the following reasons:

- If the recipient is not eligible on the date of service
- If the provider is not enrolled on the date of service
- If prior authorization is required, but not reflected
- If the service is not covered by the program
- If the claim is a duplicate of a prior claim
- If the date is invalid or logically inconsistent; or
- If the program limitations are exceeded.

RECOUPMENTS OF PAYMENTS

In situations where the third party resource payment is received after Medicaid has been billed and made payment, the provider must reimburse Medicaid. Reimbursement must be made immediately to comply with regulations. This refund mechanism is applicable to other claim situations in which an overpayment was made and a correction needs to be made. Use a void for claims less than two years old from the date of service.

Refunds should be made only in the case of claims more than two years old. Providers may reimburse Medicaid by forwarding a check; identify the claim or claims to which the refund is applied. The information necessary to identify these claims will help to reduce additional correspondence. This information can be found on the Remittance Advice (RA).

- Provider Number
- Date of Payment
- Control Number
- Recipient Name and Identification Number
- Date of Service
- Amount Paid
- Reason for Refund

Refunds should be made payable to the Department of Health and Hospitals and mailed to:

Payment Management Section
Bureau of Fiscal Services
Post Office Box 91117
Baton Rouge, LA. 70821-9117

Three-digit message codes giving reason(s) for the denial will be printed on the line immediately following the claim information. An explanation of all codes appearing on the Remittance Advice will be printed on a separate page.

Pended Claims

Pended claims are those claims held for in-house review. If after the claim is reviewed, it is determined that a correction by the provider is required, the claim will be denied. If a resolution of the claim can be made, such as a data entry error and that can be corrected, then the claim will be sent on to payment.

Claims pend for many reasons. The following are a few examples:

- Errors were made in entering in the claims processing system.
- Errors were made in submitting the claim. Only the provider who submitted the claim can correct these errors.
- The internal Medical Review section must review the claim. Claims such as sterilization claims that require patient and physician signatures on the attachments are reviewed.
- Critical information is missing or incomplete. Remember, there are five fatal errors that cause a claim to be rejected before it enters the system but there are often common mistakes made in completing the claim form such as entering the wrong date of service or the wrong procedure code. These common errors are caught during the automated claims processing.

How To Check The Status Of A Claim-Control Number

A unique 13-digit number is given to each claim. The Control Number reflected on the RA can be used to track the status of your claims.

The first four digits of the Control Number are the actual year and day the claim was received. The next seven digits tell whether the claim is a paper claim or whether it was submitted on tape and what the batch and sequence numbers are which were entered into the processing system. All claim lines on a given claim form will have the same first 11 digits.

The last two digits of the Control Number will help you to determine which line of a claim form is being referenced:

Example: 3322023456700 – Refers to the first claim line
3322023456701 – Refers to the second claim line
3322023456702 – Refers to the third claim line

For those claim types that are not processed by line such as the hospital claim form (UB-92), the Control Number for the claim will always end in 00. All multiple-line claim forms with just one service billed on line 0 will also end in 00.

The unique 13-digit Control Number can be used to determine the status of claims for receipt to final adjudication.

Remittance Advice Copy And History Requests

Provider participation in the Louisiana Medicaid Program is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. One of those standards is the agreement to maintain any information regarding payments claimed by the provider for furnishing services for a period of five (5) years.

It is the responsibility of the provider to retain all RAs for five (5) years. However, if a provider requests copies of RA or Claim Histories, the fiscal intermediary will supply this information for a fee.

No fee will be charged in cases where the provider never received a check and RA.

Requests for RAs never received must be made within three (3) weeks of the RA date or there will be a charge for this information.

If providers are requesting RAs for multiple weeks or a large volume of RAs, the fiscal intermediary will determine whether RA copies or a claim history will be provided. Requests for RAs or Claims Histories may be made in writing to:

Unisys, Provider Relations,
P.O. Box 91024
Baton Rouge, LA 70821
Telephoning 1-800-473-2783 or (225) 924-5040

The provider name and number, address, date(s) of the RA being requested, and name of the individual requesting and authorizing the request must be included in the request.

Upon receipt of the request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/History will be forwarded to the provider once payment is received.

A fee of $0.25 per page, which includes postage, is charged to any provider who requests an additional copy of a Remittance Advice of one or more pages. Claims History fees may apply at the time of order.

OTHER PROGRAM LIMITATIONS

Some services may be provided to Medicaid recipients on an unlimited basis. Others, however, may be subject to certain program limitations. Provided in this subsection is a discussion of some of the services and limitations placed on the service.

Unlimited Services

Services for Recipients under the age of 21

These services include physician visits, either on an outpatient basis or an inpatient basis with some limits covered under the concurrent care policy explained in the Professional Services Manual. Home Health visits, emergency room visits subject to the prudent layperson definition, and antibiotic injections are all unlimited but subject to medical necessity. Preventative health services are covered only for persons under the age of 21. These services are subject to the programmatic guidelines established for the service and may be subject to prior authorization by Unisys or approval by the primary care physician (PCP) in the CommunityCARE program.

Exception: These unlimited services do not apply to foster care children who do not meet Medicaid eligibility standards by have claims processed through the fiscal intermediary.

Radiation Therapy or Chemotherapy for Malignant Diseases.

These services are unlimited regardless of age.

Dialysis Treatment

These services are unlimited and do not need a referral from a PCP in order to access the service.

Diagnostic Tests

Diagnostic tests ordered by the treating physician are unlimited when they are medically necessary. The program does not cover experimental and investigational tests not approved by the FDA. Duplicative tests with no inherent repetitive benefit are not covered.

Hospitalization

Hospitals are subject to having the stay of a recipient approved by Unisys Pre-Admission Review Unit. Stays for most illnesses are reviewed by diagnosis and given a length of stay. This is a computerized process and the utilization is considered within southern regional standards of care. If the patient must stay beyond that assigned length then the hospital is required to request an extension of the stay.

For psychiatric stays, either in a freestanding facility or a distinct part unit and Long Term Care stays in a hospital a pre-admission approval is necessary. Physicians and Nurses review medical data in order to determine whether the stay meets the published guidelines of the Bureau on what constitutes a reimbursable stay.

Transportation

Non-Emergency Medical Transportation usually by means of a car, a van, or Council on Aging vehicle requires authorization by Medical Dispatch Office. Trips without authorization from the Medical Dispatch Office will not be reimbursed.

Ambulance and Non-Emergency Ambulance Transportation means all trips in an ambulance. Ambulance transportation is authorized by the attending physician at the Emergency Room or by the treating physician at the place of service by completion of the appropriate form

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Department of HEALTH and HOSPITALS
Frederick P. Cerise, M.D., M.P.H.
SECRETARY

MEMORANDUM

Date: March 23, 2007

To: Medicaid Enrolled Hospice, Wavier and Support Coordination Providers

From: Jerry Phillips
Medicaid Director

Hugh Eley
OAAS Assistant Secretary

Re: Waiver/Hospice Concurrent Care

In 2005 the Department of Health and Hospitals (DHH) clarified our policy regarding Hospice and Wavier services provided concurrently. At that time, DHH began to require recipients to forfeit their waiver services if they chose to elect hospice services. This decision was made because Medicaid administration was concerned about the possibility of duplication of services and payment in both programs.

DHH is pleased to announce that this policy has been reversed. Effective May 1, 2007, recipients may receive both hospice and waiver services concurrently. However, both hospice and waiver providers must work together to ensure that no services are duplicated. To ensure the integrity of both programs, Medicaid and OAAS collaborated to craft policy designed to reduce the possibility of duplication. Both Hospice and Waiver Providers must adhere to this policy when providing services to a Medicaid recipient that is receiving both services. This includes recipients who have both Medicare/Private Insurance and Medicaid.

If you have questions please contact Randy Davidson at (225) 342-4818.

Attachment

Hospice Waiver Recipients Policy

I. Medicaid Waiver Recipients and Hospice Services

Recipients who receive home and community-based services through one of the waiver programs offered by OAAS or OCDD are also eligible for Medicaid hospice services. These waiver programs are:

Adult Day Health Care (ADHC) Waiver
Elderly and Disabled Adult (EDA)Waiver
New Opportunities Waiver (NOW)
Children's Choice Waiver (CCW)
Supports Waiver (SW)
Note: Long Term Personal Care Services (LT PCS) is a Medicaid State Plan Service and not a waiver service; LT PCS recipients may not receive hospice services while receiving LT PCS.

II. Service Coordination

Medicaid expects the hospice provider to interface with other non-hospice providers depending on the need of the recipient to ensure that the recipient's overall care is met and that non-hospice providers do not compromise or duplicate the hospice plan of care. This expectation applies to Medicaid hospice recipients and Medicare/Medicaid hospice recipients. The hospice provider must ensure that a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid recipient to identify all other Medicaid or other state and/or federally funded program providers of care.

Medicaid waiver recipients who elect the hospice benefit do not have to disenroll from the waiver program, but they must be under the direct care of the Medicaid hospice provider for those services both programs have in common. The waiver member who elects the hospice benefit can still receive waiver services **that are not related to the terminal hospice condition and are not duplicative of hospice care.** The hospice provider and the waiver support coordinator must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member. These collaborative sessions must be documented in both the hospice and waiver case manager/support coordinator progress notes. Failure to collaborate may result in administrative sanctions.

Guidelines for hospice and waiver providers include the following:

- The hospice provider, waiver provider and waiver case manager must meet to develop a coordinated plan of care.
    - The hospice provider must prepare the hospice plan of care to include all services that the hospice provider would have covered to treat the terminal illness and related conditions had the Medicaid recipient not been on the waiver program.

- The waiver provider must prepare the waiver plan of care to include all services that the waiver provider would have covered had the Medicaid recipient not been on the hospice program.

- The waiver providers must then modify the waiver plan of care to ensure there is no duplication of services by the waiver provider for those services held in common that would be necessary to treat the terminal illness and related conditions. For example, the waiver provider must modify or adjust hours in the waiver plan of care if the hospice agency must provide personal care, attendant care, or homemaker hours to treat the terminal condition that the waiver provider would otherwise provide if the recipient had not elected hospice services.

- Different diagnoses for the respective hospice and waiver plans of care are not sufficient to ensure that there is no duplication of services. Medical records of each provider may demonstrate that a patient's primary hospice diagnosis and patient's waiver diagnosis intermingle to such a degree that it is not possible to differentiate between the waiver diagnoses and the hospice primary diagnoses.

- The fact the hospice provider and the waiver provider are in the member's home at different times is not sufficient to ensure that there is no duplication.

- Both providers must thoroughly document the required distinction between the services provided.

- The hospice provider shall be responsible for providing those services that intermingle between diagnoses. Approved waiver services shall be reduced by the appropriate level.

The hospice provider's failure to include all necessary hospice core services in the hospice plan of care for the waiver/hospice recipient subjects the hospice provider to recoupment when overpayment or duplication is identified.

III. Inquiries

Inquiries to DHH about policy clarification for the coordination of care for waiver recipients who are dually-eligible and receive Medicare hospice benefit are handled by referring the Medicare hospice to the Medicare fiscal intermediary. While Medicaid is the payor of last resort and must not under any circumstances pay for waiver services that are duplicative of Medicare hospice care, DHH has no authority to instruct a Medicare hospice provider about Medicare hospice plan of care modifications. The hospice provider must obtain clarification from Medicare.

All inquiries to DHH from waiver providers regarding coordination of hospice and waiver services will be handled by either OAAS or OCDD. Inquiries from hospice providers about the provision of Medicaid Hospice services will be handled by Medicaid Hospice staff.