NEW OPPORTUNITIES WAIVER (NOW) PROVIDER MANUAL

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New Opportunities Waiver (NOW) Provider Manual

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32.0 NEW OPPORTUNITIES WAIVER

32.1 INTRODUCTION AND OVERVIEW

The New Opportunities Waiver (NOW) is a 1915 C Waiver and is designed to provide Home and Community Based Waiver Services to recipients who otherwise would require the level of care of an Intermediate Care for the Mentally Retarded (ICFs/MR).

The mission of the NOW is to utilize the principles of Self Determination to supplement the family and/or community supports while supporting dignity, quality of life, and security in the everyday lives of people while maintaining the Recipient in the community.

Services to be provided are based on the need of the recipient and are developed using a person centered process. The person-centered process coordinated by the case manager will formulate an individualized plan for each recipient. Services identified in this manual are provided under the New Opportunities Waiver (NOW), based on need; and must be specified in the BCSS approved Comprehensive Plan of Care (CPOC). NOW services are provided as a supplement to regular Medicaid State Plan services and natural supports. NOW should not be viewed as a lifetime entitlement or a fixed annual allocation.

All NOW recipient services are accessed through the recipient's case management agency. Agencies are selected through a Freedom of Choice process. Case management is not a NOW service but is required for participation for waiver services. The "continuity of stay" rule states that a waiver service(s) must be received every 30 days. As case management is not a waiver service, it cannot be applied to the "continuity of stay" rule without receiving another NOW service. The average recipient expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF-MR services.

Providers are to follow the regulations and requirements as specified in this manual.

32.2 NOW ELIGIBILTY CRITERIA

To qualify for the NOW, a person must be three years old or older, offered a waiver opportunity slot, and meet **ALL** of the following eligibility criteria to become a NOW waiver recipient:

- MR/DD as defined in L.R.S. 28:380, et. Seq.;

- Be on the MR/DD Request for Services Registry (RFSR);
- Meet financial eligibility for Medicaid;
- Meet the medical certification eligibility;
- Meet the health and welfare requirements;
- Meet the ICF/MR level of care. The ICF/MR level of care requires active treatment of mental retardation or a developmental disability under the supervision of a qualified mental retardation or developmental disability professional;
- A resident of Louisiana and at least three years old; and
- Be a citizen of the United States or qualified alien.

If the recipient fails to meet all the above criteria, they will not be eligible to participate in NOW.

32.3 RIGHTS AND RESPONSIBILITIES FOR APPLICANTS/ RECIPIENTS OF A HOME AND COMMUNITY BASED WAIVER

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

- To be treated with dignity and respect;
- 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 they qualify for it and what to do if he/she is not satisfied;
- To work with competent, capable people in the system;
- To file a complaint, a grievance, or an appeal with his/her case management agency, direct service provider, or the Department of Health and Hospitals regarding services provided to them if he/she is dissatisfied. The recipient should call the BCSS 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 caregivers;
- To have timely access to all approved services that are identified in their Comprehensive Plan of Care (CPOC);
- To receive in writing any rules, regulations, or other changes that affect their participation in a Home and Community Based Waiver;
- To receive information explaining the case manager and the direct service provider's responsibilities and requirements in providing services to the recipient.
- To have all available Medicaid services explained to him/her and how to access these services **if they are Medicaid recipients.**

These are the **responsibilities** of an applicant for or recipient of a Home and Community Based Waiver:

- To actively participate in planning and making decisions on supports and services he/she needs.
- To cooperate in planning for all the services and supports he/she will be receiving.
- To refuse to sign any paper that he/she does not understand or that is not complete.
- To provide all necessary information about himself/herself. This will help the case manager to develop a Comprehensive Plan of Care (CPOC) that will determine what services and supports he/she 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 Bureau of Community Supports and Services' staff and his/her case manager by allowing BCSS to contact the recipient by telephone and visit him/her at home at least once quarterly. Necessary visits include pre-certification visits to assist the Bureau in providing the best services and support possible, regular home visits to assure the plan of care is sufficient to meet his/her needs, visits resulting from complaints to BCSS, and visits needed to assure the services as reported by his/her provider are being received.
- To immediately notify his/her case manager and direct service provider if their health, medications, service needs, address, phone number, alternate contact number, or their financial situation changes.
- To help the case manager identify any natural and community supports that would be of assistance to him/her in meeting his/her needs.
- To follow the requirements of the program, and if information is not clear, ask the case manager or direct service provider to explain.

- To verify he/she have received the waiver and medical services the provider says they have received, including the number of hours their direct care provider works, and report any differences to the BCSS Help Line at 1-800-660-0488.
- To understand as a recipient of the waiver program, if they fail to receive waiver services for thirty- (30) calendar days or more his/her waiver case may be closed.
- To recognize in the NOW, case management is not a waiver service and does not apply as a service in the thirty- (30) day "continuity of stay rule.
- To recognize the thirty- (30)-day "continuity of stay rule" does not apply to hospital days.
- To obtain BHSF Form 90-L "Request for Level of Care Determination" completed by their physician each year. Failure to provide this form at least 35 days prior to their annual Comprehensive Plan of Care may result in the recipient becoming ineligible to receive further waiver services. Applicants and recipients for NOW services must also provide a psychological assessment periodically as requested to continue to be eligible for services.
- To recognize that all waiver programs have an age requirement and that they will not be offered services in a program that they previously requested if they no longer meet the age requirement for that program.

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

32.4 NOW DISCHARGE CRITERIA

Recipients will be discharged from the NOW Program if <u>one</u> of the following criteria is met:

- Loss of Medicaid eligibility as determined by the parish Medicaid Office;
- Loss of eligibility for an ICF-MR level of care as determined by the Regional BCSS office;
- Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities for more than 30 days;
- Change of residence to another state with the intent to become a resident of that state;

- Admission to an ICF/MR facility or nursing facility with the intent not to return to waiver services. The waiver recipient may return to waiver services, when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days.

The recipient will be discharged from the waiver on the 91st day if the recipient is still in the ICF/MR or nursing facility;

- The health and welfare of the waiver recipient cannot be assured in the community through the provision of reasonable amounts of waiver services as determined by the Regional BCSS Office, i.e., the waiver recipient presents a danger to himself or to others;
- Failure to cooperate in either the eligibility determination process, or the initial or annual development of the approved Comprehensive Plan of Care (CPOC) or the responsibilities of the NOW recipients;
- Continuity of services is interrupted as a result of the recipient not receiving NOW services during a period of 30 or more consecutive days.
    - This does not apply to interruptions in NOW services because of hospitalization or institutionalization (such as ICFs/MR or nursing facilities. (There is a documented expectation from the treating physician that the recipient will return to NOW services.)
    - Non-routine lapses in services where the family has agreed to provide all needed or paid natural supports as documented in the CPOC. This interruption cannot exceed 90 days. During this 90-day period, the BCSS will not authorize payment for NOW services.
- Acceptance of Hospice Services under the Title XIX Medicaid State Plan. The date the recipient accepts Hospice Services, is the date the recipient is discharged from the NOW.

32.5 ACCESSING NOW SERVICES

The case manager and the case management agency are the resources to assist the recipient in the coordination of all services that are needed by the recipient.

Once his/her eligibility is determined, all NOW services are accessed through the recipient's case management agency. Case managers are selected by the recipient through a Freedom of Choice process provided by BCSS.

The case management agency develops, through a person-centered process, the Comprehensive Plan of Care (CPOC).

Involvement of the direct service provider begins upon notification from the case management agency that the recipient has chosen their agency to deliver New Opportunities Waiver (NOW) services.

Services are based on the needs of the recipient. The recipient should receive what he/she needs. The service provider shall be paid for services provided based on the BCSS approved CPOC.

Services should not be planned for the convenience of the provider. All changes in the CPOC shall be only at the request of the recipient and directed to the case manager.
All services are prior authorized (PA) and until the service provider receives prior authorization, no reimbursable services can begin. If services are provided without approved PAs, the BCSS **cannot** reimburse the provider for services rendered without prior authorization.

32.6 NOW COMPREHENSIVE PLAN OF CARE (CPOC)

The CPOC is a person-centered planning process designed cooperatively by the case manager, the recipient and other persons invited by the recipient, who may include family members, a provider, appropriate professionals, and others who know the recipient best. This NOW waiver should not be viewed as a lifetime entitlement or a fixed annual allocation. The role of the direct service provider at the CPOC meeting is to provide information and agree to the provision of services based on the needs of the recipient as stated at the CPOC meeting. The recipient's BCSS approved CPOC shall reflect only the services needed. Payment shall be made for only those approved services received by the recipient.

The BCSS approved CPOC will contain all paid and unpaid natural support services that are necessary to assist the recipient in his/her residence and promote greater independence. During the CPOC year, the recipient and family, with the assistance of their case manager and circle of support will have the flexibility within the scope of this waiver and Medicaid requirements to select the type and amount of services consistent with the recipient's needs and welfare.

The CPOC year is not defined by calendar year, State or Federal fiscal year, but rather by the specific 12 months during which the BCSS approved CPOC is in effect. If the CPOC is amended during the 12-month period, the original start/end date continues to apply for the duration of the original 12 months.

32.6.1 Now Individual Service Plan (ISP)

The service provider shall develop an individualized service plan (ISP) to meet the needs of the recipient based on the BCSS approved CPOC. This ISP must identify services to be provided to the recipient in accordance with the BCSS approved CPOC.

The ISP should be person-centered focusing on the desired outcomes; the procedures to achieve these outcomes; the person responsible; and the methods used to evaluate progress toward meeting desired personal outcomes. The ISP must be reviewed and updated as necessary to comply with the BCSS approved CPOC.

The ISP should include the following elements:

- Information about recipient's personal choices, vision, preferences, outcomes, and incorporating this into the individual's service plan
- Assessment of the recipient's skills, needed supports, health, safety, and welfare needs.
- Development of strategies to meet the recipient's identified needs, development of strategies to implement supports along with persons responsible for implementing these services, and development of strategies to address the frequency and duration of services.
- Development of a process to document and monitor the ongoing implementation of the ISP so that this information can be used for future planning,
- Submission of required data to BCSS.

32.7 NOW DIRECT SERVICE PROVIDER RESPONSIBILITIES

Recipients choose a provider agency from the Freedom of Choice list of providers offered by the Case Management Agency. Service providers shall not recruit recipients.

The direct service provider must:

- Attend the CPOC planning meeting if the recipient wants the provider in attendance. The case management agency typically gives the provider two (2) weeks notice prior to the CPOC meeting. The provider shall send a representative who has authority to actively participate and make decision regarding service delivery.

- Sign the CPOC budget page to assure that services can be provided in accordance to the proposed CPOC. The BCSS approves the CPOC and authorizes the services to be provided. Original signatures by the service provider on the CPOC budget sheet are not required. If at the time of the CPOC meeting, the service provider is unable or unwilling to sign the budget page, the case manager is still required to obtain the signature of the service provider on the budget page and submit to the BCSS Regional Office. The BCSS Regional Office will accept copied/faxed documents with the service provider signature.

- Request a written revision to the CPOC when a recipient requests a change in the number of hours of services from the service provider. The recipient requests a change in the number of hours by contacting the Case management agency. Written revisions requests must be submitted to BCSS 7 days prior to the request date of the change.

- Request a written revision to the CPOC when an emergency arises and the recipient need a change in the number of hours of services. The request must be sent to the BCSS for approval. These emergency revisions must be initiated by the case manager and sent in to the BCSS within 24 hours.

- Develop an individualized service plan to meet the needs of the recipient based on the BCSS approved CPOC. This service plan must identify services to be provided to the recipient in accordance with the BCSS approved CPOC. The service should be person-centered focusing on the outcomes and the procedures to achieve these outcomes along with the person responsible and methods used to evaluate progress toward meeting personal outcomes.

- Track the services provided for each recipient. The service provider will be held accountable for any service provided over the authorized amount in the BCSS approved CPOC. BCSS will not reimburse for any service(s) provided that were not authorized and on the BCSS approved CPOC.

- Report and document any incidents/complaints/abuse to the case manager/BCSS/ Appropriate law Enforcement Agency within two hours of first knowledge. Refer to the section on Incident/Complaint Reporting for additional instructions.

- Continue to meet all assurances of DHH licensing, DSS licensing, Medicaid enrollment and BCSS policies.

- Keep accurate and timely documentation regarding service delivery. This would include documentation in the form of progress notes, service logs, time sheets and verification of services. The provider shall make available without cost to BCSS all requests by BCSS for required documentation. A simple checklist used alone without individualized documentation will not be considered adequate. See the section on sanctions for more information.

- Keep BCSS and case manager informed on any address, telephone number, or other demographic changes in the agency, including name of person actually delivering the services.
- Communicate and cooperate with the case managers in the planning and coordination of services.
- Provide the case management agency with written documentation of the services provided, documentation of progress toward the individual's goal and outcomes and documentation of authorized services remaining in the BCSS approved CPOC, when a recipient request to change service providers .
- Maintain the required license and be enrolled in Medicaid to provide all services.
- Maintain confidentiality of recipient's records and information based on Medicaid and HIPAA requirements.

32.8 CHANGING DIRECT SERVICE PROVIDERS

The recipient may change direct service provider agencies once every services authorization quarter (3 months) with the effective date being the beginning of the following quarter or for good cause approved by BCSS State Office. Once the recipient has decided to change direct service providers, he/she shall notify his/her case manager.

The case manager 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.
- Obtain 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 BCSS 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".

"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; or,
- Safety, health, and welfare have been compromised and/or the direct service provider has not rendered satisfactory services to the recipient.

32.9 Service Provider Documentation of Services and Prior Authorization

When a recipient changes service providers, the former service provider must provide the case management agency with written documentation of the services provided, time sheets, documentation of progress toward the recipient's goal and outcomes and documentation of authorized services remaining in the BCSS approved CPOC.

A new PA number will be issued to the new service provider with an effective starting date of the first-day of the new quarter or the first day of the first-full-calendar-month. BCSS or its agent **in no case** will backdate the PA period prior to the first-day of the first-full-calendar-month in which the FOC/Transfer of Records Section is completed. The transferring agencies PA number will expire on the date of transfer of records (first-day of the first-full-calendar-month).

Lack of cooperation in the transfer process must be reported to the BCSS Help Line at 1-800-660-0488. The BCSS NOW Program Manager will review all allegations of failure to cooperate.

32.10 SERVICES FOR THE NEW OPPORTUNITES WAIVER

32.10. 1 INDIVIDUALIZED AND FAMILY SUPPORT (IFS) SERVICES – DAY (Attendant Care Services - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Individualized and Family Support (IFS) services are defined as day and/or night direct support and assistance for recipients three years of age and older, or for the relief of the care giver, in or out of the recipient's residence, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in his/her person-centered plan.

Individualized and Family Support services can be shared by related waiver recipients or up to three unrelated waiver recipients who choose to live together. These services can be provided in a variety of settings, and the waiver recipients may share IFS services staff when agreed to by the recipient and health and welfare can be assured for each recipient. Based on an individual-by-individual determination, the sharing staff shall be reflected on each recipient's BCSS approved CPOC as a special billing code and rates are adjusted accordingly. Due to requirements of privacy and confidentiality, recipients who choose to share supports must agree to sign a release of confidentiality form to facilitate the coordination of services.

Transportation is included in the rate paid to the provider for Individual Family Support. Therefore the IFS worker can provide transportation.

32.10.1.1 Description of Services

- Assistance and prompting with personal hygiene, dressing, bathing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated.
- Assistance and/or training in the performance of tasks related to maintaining a safe, healthy and stable home, such as housekeeping, bed making, dusting, vacuuming, laundry, cooking, evacuating the home in emergency situations, shopping, and money management. This does not include the cost of the supplies needed or the cost of the meals themselves.
- Personal support and assistance in participating in community, health, and leisure activities. This may include accompanying the recipient to these activities.

- Support and assistance in developing relationships with neighbors and others in the community and in strengthening existing informal, social networks and natural supports.
- Enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences. Volunteer work, community awareness activities and/or teaching.
- Providing orientation and information to acute hospital nursing staff concerning the recipient's specific Activities of Daily Living (ADL's), communication, positioning, and behavioral needs. While the recipient is in the hospital, all decisions regarding medical care will be made by appropriate medical staff. The IFS day worker can perform support functions, such as facilitating communication needs, assistance with eating, assistance with positioning and assistance with behavioral supports. The specific functions must be outlined on the BCSS approved CPOC and cannot be duplicative of personal care services provided by the hospital.
- Individualized and Family Support (IFS) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the recipient. Waking hours are defined as the period of time when the recipient is awake and can be day or night. Direct services shall be those services that would support the recipient with challenging behavior and assist the recipient with his/her daily living skills, positioning, or training, and will not be medical procedures. The cost of transportation is included in the cost of theses services.
- Additional hours of IFS day services beyond the 16 hours can be approved based on documented need, which can include medical or behavioral and specified in the BCSS, approved CPOC. Three months of documentation, which would include progress notes, will be necessary to substantiate the request for additional hours of day services beyond the 16 hours. The BCSS Regional Office will determine the decision for request for additional hours of IFS day services.
- Any service outlined in Individualized and Family Support – Day services may be provided by the IFS-N worker

32.10.1.2 Special Limitations

- To bill for IFS-D services, the recipient and family support day worker must be present, awake, alert, and available to respond to the recipient's immediate needs.
- The IFS-D worker may not work more than 16 hours in a 24-hour period of combined IFS-D and IFS-N unless there is a documented emergency or a time limited, non-routine need documented in the BCSS approved CPOC.

Time limited, non-routine could include family vacations, business trips, summer camps, and others. For recipients who live at home with family and the family is going on vacation, or business trip for a time limited non-routine basis, or in an emergency, the recipient could stay at home and the IFS –D worker exceed the 16 hours. Emergencies could include natural acts of God such as flooding, hurricane, tornadoes, or other emergencies.

- In agreement with licensing regulations, services cannot be provided in the IFS-D worker's residence, regardless of relationship, except if the IFS- D worker's home is a certified foster care home.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as Day Habilitation, Supported Employment Models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Center-Based Respite, Skilled Nursing Services, Individualized and Family Support Night, Shared Supports (Day/Night), or Community Integration Development.
- In no instance should a recipient be left alone when IFS-D services are being provided.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen consumer direction.
- IFS-D employees may be members of the recipient's family, provided the recipient does not live in the family member's residence. Payment will not be made for services furnished by a legally responsible relative defined as: parent of a minor child, foster parent, tutor, curator, legal guardian; or the recipient's spouse.
- Family members who provide IFS-D shall meet the same standards as other IFS-D workers who are unrelated to the recipient.
- Supervision of the IFS service worker shall be furnished by the licensed IFS provider agency, licensed Supervised Independent Living (SIL) agency as specified by state licensing. In the Consumer Direction option, the recipient or his/her representative, including the direct service provider, will provide supervision.
- Individualized and Family Support services must be provided in the State of Louisiana. Exceptions to provide IFS-D services outside of Louisiana, but only within the United States or territories of the United States, must be prior approved and for time-limited periods or emergencies
- IFS-D services will not be authorized or provided outside the United States or territories of the United States.

- Must comply with federal wage and hour laws.
- Request for IFS-D services for vacation, can be approved at the current level the recipient receives of IFS-D services. Additional hours of support for vacations may be approved based on the need of the recipient and documentation to support the need of the recipient.

32.10.1.3 Agency Provider Type

Providers must be licensed by Department of Social Services and enrolled Medicaid Home and Community Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.2 Individualized and Family Support Services –Night (Attendant Care Services - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, IFS-N service is the availability of direct support and assistance provided to recipients three years of age and older with disabilities while sleeping. Individualized and Family Supports can be shared by related waiver recipients or up to three unrelated waiver recipients who choose to live together. These services can be provided in a variety of settings and the waiver recipients may share IFS services staff when health and welfare can be assured for each recipient. Based on an individual-by-individual determination, the shared staff shall be reflected on the BCSS approved CPOC as a special billing code. Rates are adjusted. The IFS-N must be awake, alert, immediately available, and in the same residence as the recipient to be able to respond to the recipient's immediate needs. Night hours are the period of time when the recipient is asleep and there is a reduced frequency and intensity of required assistance and are not limited to traditional night time hours.

Documentation must support this level of assistance. Due to requirements of privacy and confidentiality, recipients who choose to share supports must agree to sign a release of confidentiality form to facilitate the coordination of services.

32.10.2.1 Special Limitations

- To bill for this service, the recipient and the IFS-N worker must be present.
- Must be a minimum of 8 hours for recipients who have 24-hour period, but cannot exceed 24 hours combination of day and night.

The number of IFS-N service for recipients who receive less than 24 hours of paid support is based on need and specified in the BCSS approved CPOC.

- The IFS-N worker may not work more than 16 hours in a 24-hour period, of combined support, unless there is a documented emergency or a time limited non-routine need documented in the BCSS approved CPOC.
- Habitual patterns of 16 hour plus work will be investigated.
- In agreement with licensing regulations, services cannot be provided in the IFS-Day or Night worker's residence, regardless of relationship, except if the IFS-N worker's home is a certified foster care home.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitation Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Center-Based Respite, Skilled Nursing Services, Individualized and Family Supports – Day, Shared supports day or night, or Community Integration Development.
- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Family members who provide IFS-N services shall meet the same standards as other IFS-N workers unrelated to the recipient.
- IFS-N employees may be members of the recipient's family, provided the recipient does not live in the family member's residence. Payment will not be made for services furnished by a legally responsible relative defined as a: parent of a minor child, foster parent, curator, tutor, legal guardian or the recipient's spouse.
- Supervision of the IFS-N service worker shall be furnished by the licensed IFS provider agency. In the Consumer Direction option, the recipient or his/her representative, including the direct service provider, will provide supervision.
- IFS-N services will not be authorized or provided outside the United States or territories of the United States.
- Individualized and Family Support-Night services must be provided in the State of Louisiana. Exceptions to provide IFS services outside of Louisiana, but only within the United States and territories of the United States, must be prior approved and for time-limited periods or emergencies.
- Hours for vacation request for IFS-N can be approved at the current level the recipient receives. Additional hours of support for vacations may be approved based on the need of the recipient and documentation to support the need of the recipient.

32.10.2.2 Agency Provider Type

Providers must be licensed, by Department of Social Services, and enrolled as a Medicaid Home and Community Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.3 Shared Supports (SS) – Day and Shared Support – Night (Attendant Care Services - HIPAA Code Name)

Individualized and Family Support services can be shared by related waiver recipients who live together or up to three unrelated waiver recipients who choose to live together.

These services can be provided in a variety of settings and the waiver recipients may share IFS services staff when health and welfare can be assured for each recipient. When recipients share supports, this is known as shared supports services, both day and night.

Based on an individual-by-individual determination, the shared staff shall be reflected on the BCSS approved CPOC as a special billing code. Rates are adjusted. Due to requirements of privacy and confidentiality, recipients who choose to share supports must agree to sign a release of confidentiality form to facilitate the coordination of services.

32.10.3.1 Special Limitations

- To bill for this service, the recipient and the Individual and Family Shared Support day/night worker must be present.
- The Shared Support Worker may not work more than 16 hours, in a 24-hour period, combination IFS-D and IFS-N service unless there is a documented emergency. Habitual patterns of 16 hour plus work will be investigated.
- Must be a minimum of 8 hours of night-shared support for recipient's receiving 24-hour period for shared night support not to exceed 24 hours for day and night combined.
- Cannot include services provided in the shared support worker's residence, regardless of relationship, per licensing regulations, unless the shared support worker's home is a certified foster care home.
- Must be billed in 15-minute increments.
- Cannot be provided for or billed for at the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Center-Based Respite,

Skilled Nursing Services, Day-Night Individualized and Family Supports, or Community Integration Development.

- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- IFS-SS D/N employees may be members of the recipient's family, provided the shared support worker is not the legally responsible relative. Payment will not be made to legally responsible relative defined as a parent of a minor, foster parent, curator, tutor, legal guardian, or the recipient's spouse.
- Family members who provide IFS-SS services must meet the same standards as IFS-SS workers who are unrelated to the recipient.
- Supervision of the IFS-SS service worker shall be furnished by the licensed IFS provider agency. In the Consumer Direction option, the recipient or his/her representative, including the direct service provider, will provide supervision.
- Individualized and Family Support-Shared Supports services must be provided in the State of Louisiana. Exceptions to provide IFS-SS services outside of Louisiana, but only within the United States or territories of the United States, must be prior approved and for time-limited periods or emergencies.
- IFS-N services will not be authorized or provided outside the United States or territories of the United States.
- Hours for vacation request for IFS-SS can be approved at the current level the recipient receives. Additional hours of support for vacations may be approved based on the need of the recipient and documentation to support the need of the recipient.

32.10.3.2 Agency Provider Type

Providers must be licensed by Department of Social Services and enrolled as a Medicaid Home and Community Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.4 Individual and Family Support Workers Accompanying Recipients to the Hospital

Policy

The NOW policy will allow the Individual and Family Support worker(s) to accompany recipients to the hospital and this service must be on the BCSS approved Comprehensive Plan of Care (CPOC).

- The IFS worker can provide orientation and information to the acute hospital nursing and medical staff concerning the recipient's activities of daily living (ADLs), which includes communication, positioning, and behavioral needs.

- The IFS worker can provide support functions such as facilitating communication needs, assistance with eating, assistance with positioning and assistance with behavioral supports.

- Decisions regarding medical care of the recipient will be made by the appropriate hospital medical staff, the recipient or the recipient's legally responsible representative and not the IFS worker.

- The functions and service of the IFS worker accompanying the recipient to the hospital must be on the BCSS approved CPOC.

Procedure

- When a recipient is to go to the hospital for whatever medical reason, either an emergency or a planned admission, the current BCSS approved CPOC must be revised to reflect the addition of this need.

- The recipient shall, if capable, notify the case management agency of the need for their IFS worker to accompany them to the hospital. In cases of an emergency situation, where the recipient is unable to communicate the need of the emergency, the IFS worker shall immediately notify a family member(s) or the recipient's legally responsible representative regarding the emergency and immediately notify the case manager of the emergency.

- The case management agency must submit the revision to the BCSS Regional Office within the timelines of submitting a revision request. For an emergency revision request, it is within 24 hours and for a non- emergency revision request, it is 7 days prior to the requested date.

- Once the recipient's date of discharge has been determined, the recipient, or recipient's legally responsible representative, or the IFS worker shall notify the case manager of the scheduled date of discharge.

- Once the recipient is discharged from the hospital, the CPOC must be revised to delete the need for the IFS worker at the hospital.

- The case management agency must submit this revision request within 7 days from the recipient's date of discharge.

32.10.5 POLICY FOR EXCEEDING THE 16 HOURS FOR INDIVIDUAL AND FAMILY SUPPORT WORKERS

Policy

The Bureau of Community Supports and Services (BCSS) may approve Individual and Family Support day workers to work more than 16 hours in a 24 hour period, in the following circumstances and must be documented on the BCSS approved Comprehensive Plan of Care (CPOC):

- On a non-routine and time limited basis, that could include vacations, business trips, or other documented need.

- Emergency situations that could include hurricane, tornado, flooding, or other acts of God.

Procedure

- The recipient would notify the case management agency of the need for the worker to work beyond the 16 hours.
- The case management agency would submit a revision request to the BCSS Regional Office with supporting documentation to justify the need.
- The revision request for emergency situations as defined above must be done within 24 hours of the emergency.
- The revision request for the need identified that can be planned in advance, such as vacations, business trip, must be submitted within 7 days of the planned need.
- The BCSS Regional Office will review the documentation notify the case management agency of the decision.

32.10.6 CENTER BASED RESPITE CARE
(Respite Care - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Center-Based Respite (CBR) Care is temporary, short-term care provided to recipients three years of age and up when unable to care for himself/herself, to prevent him/her from being institutionalized.

The service is provided for a recipient with developmental disabilities who requires support and/or supervision in his/her day-to-day life, in the absence of his/her primary care giver. Recipient's routine is maintained while receiving Center-Based Respite Care in order to attend school, work, or other community activities/outings. Community outings shall be included in the BCSS approved CPOC and shall include school attendance, other school activities, or other activities the recipient would receive if they were not in a center-based respite center. The respite center is responsible for providing transportation for community outings, as this is included in their reimbursement. This would allow the recipient's routine to be uninterrupted. In accordance with Licensing regulations and BCSS policy, no other NOW services can be authorized while the recipient is in Center Based respite, as Center Based respite services are to meet all the needs of the recipient.

32.10.6.1 Special Limitations

- To bill for this service, the recipient and center-based respite worker must be present.
- Shall not exceed 2,880 1/4 hours units, which equals 720 hours per recipient per CPOC year.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day or Night, Shared Support- Day or Night, Skilled Nursing Services, or Community Integration Development.
- Transportation for community outings will be provided by the Respite Center.
- Payment to provider does not include cost of room and board.
- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.6.2 Agency Provider Type

Providers must be licensed by Department of Social Services and enrolled as a Medicaid Home and Community Based Waiver service provider of Center-Based Respite Care.

32.10.7 COMMUNITY INTEGRATION DEVELOPMENT
(Waiver services not otherwise specified - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Community Integration Development (CID) is the development of opportunities to assist recipients 18 years and older in becoming involved in their community with the creation of natural supports. The purpose is to encourage and foster the development of meaningful relationships in the community reflecting the recipient's choices and values, i.e., doing preliminary work toward membership in civic, neighborhood, church, leisure, etc. groups. CID is for the development of community connections and should not to be confused with IFS. Payment for this service includes the development of a service plan. Two recipients may choose to share CID workers with each recipient's CPOC revised accordingly.

32.10.7.1 Special Limitations

- Recipient must be 18 years and older.
- To bill for Community Integration Development (CID), the recipient and CID worker providing this service **shall** be present.
- It will be person-centered, plan-driven, with a cap of 60 hours per recipient per CPOC year, which includes the combination of shared and non-shared CID.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for on the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support-Day-Night, Shared Support – Day – Night, Skilled Nursing Services, or Center-Based Respite.
- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Transportation cost included in the rate paid to the provider.

32.10.7.2 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled Medicaid Home and Community-Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.8 ENVIROMENTAL ACCESSIBILITY ADAPTATIONS

(Environmental Accessibility - ramp - HIPAA Code Name)
(Environmental Accessibility - lift - HIPAA Code Name)
(Environmental Accessibility - bathroom - HIPAA Code Name)
(Environmental Accessibility - other - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Environmental Accessibility Adaptations are physical adaptations to the home and/or vehicle which are necessary to ensure the health, welfare and safety of recipients three years and up, or which enable the recipient to function with greater independence in the home, and without which the recipient would require additional supports or institutionalization. Repairs to environmental accessibility adaptations to the home and/or vehicle provided under NOW will not be authorized by BCSS. Also, BCSS will not authorize repairs or modifications to previously installed lifts or adaptations not provided under NOW.

Such adaptations to the home may include the installation of non-portable ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies for the welfare of the recipient. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of BCSS.

Such adaptations to the vehicle may include a lift, or other adaptations to make the vehicle accessible to the recipient, or for the recipient to drive.

The Environmental Accessibility Adaptation(s), whether from an original claim, a corrected claim, a resubmit or revision CPOC or claim, must be accepted, fully delivered, installed, operational, and reimbursed in the current CPOC year that it was approved.

Three written itemized detailed bids, including drawings with dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted. The lowest bid will be authorized by BCSS. Recipient or family preference for a specific builder/installer is not sufficient justification for approval of a higher bid. Modification may be applied to rental or leased property with the written approval of the landlord.

Three bids may not be required to be submitted if there are no other Environmental Accessibility Adaptations providers in the region. Justification and agreement by the service planning interdisciplinary team for not providing three bids **must** be included with any request for prior approval. BCSS Regional Office will determine whether three bids are required and notify the case manager of its determination. Case managers will contact the BCSS Regional Office before approving modifications for an individual leaving an ICF/MR.

This documentation shall be submitted with all requests. Payment will not be authorized or made until written documentation that the job is completed, and the job has been completed to the satisfaction of the recipient.

When state and local building or housing code standards are applicable, modifications to the home shall meet such standards. The BCSS Regional Office must approve the Environmental Modifications Job Completion Form (Form BCSS-PF-03-010).

32.10.8.1 Special Limitations

- Cap of $4,000 per recipient for Environmental Accessibility Adaptations. Once 90% (≥$3,600) of the cap is reached and no additional expenditures are made for a three-year period, the recipient may again access the $4,000. Any additional Environmental Accessibility expenditures during this three-year period reset the three-year time frame.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Excluded are those adaptations or improvements to the residence that are of general utility or maintenance and are not of direct medical or remedial benefit to the recipient, such as:
    - Flooring (carpet, wood, vinyl, tile, stone, etc.)
    - Interior/exterior walling not directly affected by a modification
    - Lighting or light fixtures that are for non-medical use
    - Furniture
    - Roofing, initial or repairs, this also includes covered ramps, walkways, parking areas, etc.
    - Air conditioning or heating (solar, electric, or gas; central, floor, wall, or window units, heat pump-type devices, furnaces, etc.)
    - Exterior fences, or repairs made to any such structures
    - Motion detector or alarm systems for fire, security, etc.
    - Fire sprinklers, extinguishers, hoses, etc.

- Smoke and carbon monoxide detectors
- Interior/exterior non-portable oxygen sites
- Replacement of toilets, Septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring, or fixtures when not affected by a modification, not part of the installation process, or not one of the pieces of medical equipment being installed.
- Appliances (Washer, dryer, stove, dishwasher, vacuum cleaner, etc)
- Adaptations, which add to the total square footage or add total living area under the roof of the residence, are excluded from this benefit.

- Car seats are not considered as a vehicle adaptation.
- 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, but in any situation must pay for a specific approved adaptation.
- Vehicle modifications are designed to help the recipient function with greater independence. Excluded are those adaptations, which are of general utility, or for maintenance of the vehicle, or for repairs to adaptations.
- 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). When state and local building or housing code standards are applicable, modifications to the home shall meet such standards.
- Any services covered by Title XIX (Medicaid State Plan Services) are excluded.
- Any services denied by Title XIX (Medicaid State Plan Services) are not reimbursable.

32.10.8.2 Agency Provider Type

Providers must be enrolled as Medicaid Home and Community-Based Services Waiver Environmental Accessibility Adaptation service provider. When required by state law, the person performing the service must meet applicable requirements for professional licensure. When building code standards are applicable, modifications to the home shall meet such standards.

32.10.9 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SES)

(Medical Equipment and Supplies - lifts - HIPAA Code Name)
(Medical Equipment and Supplies - switches - HIPAA Code Name)
(Medical Equipment and Supplies - controls - HIPAA Code Name)
(Medical Equipment and Supplies - other - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Specialized Equipment and Supplies (SES) are specified devices, controls, or appliances, which enable recipients to increase their ability to perform the activities of daily living, ensure safety, or to perceive and control the environment in which they live.

This service also includes items medically necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and medically necessary durable and non-durable medical equipment not available under the Medicaid State Plan. NOW will not cover or reimburse for Specialized Medical Equipment and Supplies eligible for payment under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design, and installation. Pictures, brochures, and or other descriptive information must accompany the Specialized Medical Equipment and Supplies Job Completion Form (BCSS Form BCSS-PF-03-009) and must be approved by the BCSS Regional Office.

Some examples would include sip and puffer switches, other specialized switches, voice activated, light activated, or motion activated devices to access the recipient's environment. Generators could be covered for recipient's whose medical condition(s) warrants it, such as recipients with ventilators.

Case managers shall pursue and document all alternate funding sources that are available to the recipient, and alternate funding sources the recipient may be eligible, before submitting a request for approval to purchase or lease Specialized Medical Equipment and Supplies.

To avoid delays in service provisions/implementation, the case manager should be familiar with the process for obtaining Specialized Medical Equipment and Supplies or durable medical equipment (DME) through the Medicaid State Plan.

32.10.9.1 Special Limitations

- Cap of $4,000 per recipient for Medical Equipment and Supplies. Once 90% ($\geq$$3,600) of the cap is reached and no additional expenditures are made for a three-year period, the recipient may again access the $4,000. Any additional Medical Equipment and Supplies expenditures during this three-year period resets the three-year time frame.

- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Excluded are those specialized equipment and supplies that are of general utility or maintenance and are not of direct medical or remedial benefit to the recipient, such as:
    - Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.) swimming pool, hot tub, etc. eye exams, athletic and tennis shoes, automobiles, van lifts attached to van other than the recipient's or the recipient's family, adaptive toys, recreation equipment (swing set, etc.)
    - Personal computers and software, daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, q-tips, etc.)
- Rent subsidy, food, bed covers, pillows, sheets, etc. exercise equipment, taxi fares, Intra and Interstate transportation services bus passes, pagers including monthly service, telephones including mobile telephones and monthly service, Home Security Systems, including monthly service.

32.10.9.2 Agency Provider Type

The provider must be enrolled as a Home and Community-Based Service Waiver service agency of specialized medical equipment and supplies.

32.10 .10 RESIDENTIAL HABILITATION SUPPORTED INDEPENDENT LIVING (Companion Care, HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Residential Habilitation-Supported Independent Living (SIL) services are provided in the recipient's residence or in the community. The residence of the recipient includes his/her apartment or own home provided the recipient does not live in the residence of any legally responsible relative(s) as defined in Individual and Family Supports.

Family Members who are not legally responsible relatives can be SIL workers provided they meet the same qualifications as any other non-related SIL worker. Exceptions are for recipients living in the residence of his/her spouse or disabled parent, or a parent aged 70 or older. The direct service provider cannot be the homeowner/landlord unless the home is a HUD home. Recipients must be able to choose to receive supports from any provider on the Freedom of Choice list in their region.

Payment for this service includes oversight and administration and the development of service plans for the development and enhancement of socialization, with age-appropriate activities, which provide enrichment and may promote wellness, as indicated in their individual service plan. The individual service plan should include outcomes expected for community-integration development that could include initial, introduction to and exploration activities for positive outcomes for the recipient.

Residential Habilitation-Supported Independent Living (SIL) is assistance and/or training in the performance of tasks related to maintaining, acquiring, or improving skills, such as, but not limited to, personal grooming, bathing, housekeeping, bed making, dusting, vacuuming, laundry, cooking, shopping, and money management. Minimum direct services include three documented contacts per week, by the SIL provider agency, with at least one contact being face-to-face in addition to the approved direct support hours.

These services will also assist with social, community, and adaptive skills necessary to enable the recipient to reside in the community of their choice and to participate as independently as possible, and to prevent institutionalization and/or divert him/her from becoming institutionalized.

These services will also assist in obtaining financial aid, assistance in accessing other benefits available, advocacy and self-advocacy training as appropriate, and emergency support, providing trained staff and assisting the beneficiary to access other programs for which he/she qualifies.

These services shall be coordinated with any services listed in the BCSS approved CPOC and may serve to reinforce skills or lessons taught in school, therapy, or other settings.

32.10.10.1 Special Limitations

- To bill for this service, the SIL provider must maintain required activities for and with the recipient.
- SIL settings cannot be in a substitute family care setting.
- Cannot exceed 365 days per year.
- Services are limited to once a day, per CPOC year. When a recipient is in SIL and is admitted to a Center-based respite (CBR) facility, the SIL provider cannot bill the SIL per diem beginning with the date of admission to the CBR through the date of discharge from the CBR.
- The recipient must be 18 years or older to receive SIL services.

- No more than 3 people can live together and share an SIL setting unless they are related.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- The provider shall provide 24 hour back up.
- Legally responsible relatives may not be SIL providers.
- SIL per diem payment will not be paid to SIL provider agency for recipient's participating in the Consumer Direction as the recipient will be directing his or her own care.
- The per diem maybe billed when the SIL recipient is in the hospital.
- Cannot include the cost of:
    - Supplies needed or the cost of the meals themselves
    - Room and board
    - Facility maintenance
    - Upkeep and improvement
    - Direct or indirect payment(s) to Legally Responsible Relatives.
    - Routine care and supervision which should be expected to be provided by a family or a group home provider
    - Activities or supervision by a source other than Medicaid (OCDD, etc.) for which a payment is made.

32.10.10.2 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled Home and Community-Based Service Waiver service SIL provider, or an individual providing support under authorized Consumer Directed Services.

32.10.11 DAY HABILITATION

Day Habilitation Waiver - HIPAA Code Name)

Based on need, specified in the BCSS approved Comprehensive Plan of Care, Day Habilitation is provided in a community based setting for the 18-year-old and older recipient that focuses on

socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in their person-centered plan. This is not Adult Day Health Care. Day habilitation services begin when both the recipient and the day habilitation worker are present.

The recipient will be given assistance and/or training in the performance of tasks related to maintaining, acquiring, or improving skills such as, but not limited to, personal grooming, housekeeping, bed making, dusting, vacuuming, laundry, cooking, shopping, and money management.

This service will also assist with social and adaptive skills necessary to enable the recipient to reside in a non-residential setting and to participate as independently as possible in the community. Habilitation service shall be coordinated with any therapies listed in the Comprehensive Plan of Care, as well as Employment Related Training, Mobile Crew, or Enclave and may serve to reinforce skills or lessons taught in school, therapy, or other settings. The recipient does not get paid for the activities in which he/she is involved. The provider must develop an individual service plan to address the outcomes for the recipient.

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

- A recipient receives assistance and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated.
- A recipient receives personal care skills training at a facility to improve his/her adaptive skills.
- A recipient participates in a community inclusion activity designed to enhance his/her social skills.
- A recipient receives training in basic nutrition and cooking skills at a community center.
- An older recipient is supported in participating with a group of senior citizens in a structured activity. This may include activities such as community-based activities sponsored by the local Council on Aging.
- A recipient is provided with aerobic aquatics in an inclusive setting to maintain his/her range of motion.
- A recipient is taught how to use a vacuum cleaner.
- A recipient learns how to make choices and order from a fast food restaurant.
- A recipient is taught how to observe basic personal safety skills.

- A recipient does non-paid work in the community along side peers without disabilities to improve social skills and establish connections.
- A recipient and, as appropriate, his/her family receive information and counseling on benefits planning and assistance in the process.

32.10.11.1 Agency Provider Type

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Medicaid Home and Community Based Services Waiver service provider of day habilitation.

32.10.11.2 Special Limitations

- To bill for day habilitation services, both the recipient and the day habilitation worker must be present.
- The recipient must be 18 years or older
- Can be for 1 or more hours per day but not to exceed 8 hours per day.
- Cannot exceed 8,320 ¼ hour units in a CPOC year.
- Cannot be provided or billed for at the same hours on the same day as; Supported Employment models, Employment Related Training, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day or Night, Shared Supports – Day or Night, Community Integration Development, or Center-Based Respite.
- Must be billed in 15-minute increments.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.11.3 Transportation for Day Habilitation
(Non-emergency transportation - HIPAA Code Name)
(Non-emergency transportation - wheelchair - HIPAA Code Name)

Only round-trip transportation will be reimbursed. The recipient may receive Day Habilitation in more than one place.

This daily round trip rate includes as many trips as necessary for Day Habilitation activities in one day, but must have at least one round trip documented in order for the provider to bill on any given recipient. Round trip is defined as transporting from the recipient's place of residence and returning to the recipient's place of residence. The service provider must only bill transportation for the date(s) on which the recipient has received Day Habilitation services based on the BCSS approved CPOC. This service shall be documented in the recipient's record and the round trip shall be documented in the provider's transportation log. The provider's vehicles used in transporting recipients must be in good repair, have a current Louisiana inspection sticker, first aid kit, and must carry $1 million dollars liability insurance. Drivers must have a current Louisiana driver's license applicable to the vehicle being used.

32.10.11.4 Agency Provider Type

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Home and Community Based Services Waiver service provider for Day Habilitation or an individual providing support under authorized Consumer Directed Services.

32.10.12 SUPPORTED EMPLOYMENT
(Supported Employment - HIPAA Code Name)

These are services not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17). Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the individuals are working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of individuals with ongoing support services for whom competitive employment has not traditionally occurred. Theses are services provided to recipients who are not served by Louisiana Rehabilitation Services and need more intense, long-term follow along and usually cannot be competitively employed because supports cannot be successfully faded.

Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by recipients receiving Waiver services, including supervision and training.

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

Supported employment includes assistance and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated.

The three Supported employment models are:

- **One On One Intensive (Supported Employment)– HIPAA Code Name**

A supported employment placement strategy in which an employment specialist (job coach) places a person into competitive employment, provides training and support, and then gradually reduces time and assistance at the work site once a certain percentage of the job is mastered by the recipient. Once the recipient has mastered the job task, then they maybe transitioned to the follow along status of supported employment, if needed. One on one intensive service is time limited and usually six to eight weeks in duration.

A recipient can move from follow along back to one to one intensive if the job changes or a new job has been secured for the recipient and new tasks have to be learned.

Special Limitations for One To One Intensive

- To bill for this service, the recipient and One on One worker must be present.
- Cannot exceed 1,280 ¼ hour units per CPOC year.
- Typically 6-8 weeks in duration.
- Cannot exceed 8 hours a day, and cannot exceed 5 days a week.
- Must be 18 years or older
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Employment Related Training, Mobile/crew enclave, follow along, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Support – Day and Night, Community Integration Development, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

- **Follow Along - (Ongoing Support to maintain Employment-HIPAA Code Name)**

Ongoing follow along services are supports to maintain the recipient in their job and these follow along services must be provided by another entity other than the Louisiana Rehabilitation Services.

The ongoing follow along support services must include at a minimum, twice monthly face-to-face contacts with the recipient at their work site. Ongoing support services can be provided from more than one source.

Special Limitations to Follow Along

- To bill for this service, the recipient and follow along worker must be present.
- Not to exceed 2 follow along contacts per calendar month and cannot exceed 24 days per recipient per CPOC year, without additional documentation.
- The recipient must be 18 years or older
- Must be billed by the daily per diem.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Employment Related Training, One-to-One intensive, Mobile Work Crew/Enclave, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Support – Day and Night, Community Integration Development, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

- **Mobile Work Crew/Enclave (Ongoing support to maintain employment-HIPAA Code Name)**

An employment situation in competitive employment in which a group two or more workers, but fewer than eight workers, with disabilities are working at a particular work setting under the supervision of a permanent employment specialist (job coach/supervisor). The disabled workers may be disbursed throughout the company and among non-disabled workers, or congregated as a group in one part of the business.

Special Limitations to Mobile Crew/Enclave

- To bill for this service, the recipient and Mobile Work Crew/Enclave worker must be present.
- Cannot exceed 8,320 ¼ hour units per CPOC year
- Not to exceed 8 hours a day, 5 days a week.
- The recipient must be 18 years or older
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Employment Related Training, One-to-One intensive, Follow Along, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Support – Day and Night, Community Integration Development, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.12.1 Agency Provider Type for All Three Models Of Supported Employment

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Home and Community Based Services Waiver service provider for Supported Employment, or an individual providing support under authorized Consumer Directed Services.

32.10.12.2 Transportation for Supported Employment
(Non-emergency transportation - HIPAA Code Name)
(Non-emergency transportation - wheelchair- HIPAA Code Name)

Only round-trip transportation will be reimbursed when provided between the recipient's place of residence and the site of the supported employment models of service; or between supported employment model sites (cases in which the recipient receives supported employment services in more than one place), is reimbursable.

The round-trip rate includes as many trips as necessary for supported employment model activities in one day, but must have at least one round trip documented in order for the provider to bill on any given recipient. Round trip is defined as transporting from the recipient's place of residence and return transporting to the recipient's place of residence.

The service provider must only bill transportation for the date(s) on which the recipient has received supported employment models based on the BCSS approved CPOC. This service shall be documented in the recipient's record and the round trip shall be documented in the provider's transportation log.

Service provider vehicles used in transporting recipients must be in good repair, have a current Louisiana inspection sticker, first aid kit, and must carry $1 million dollars liability insurance. Drivers must have a current Louisiana driver's license applicable to the vehicle being used.

32.10.12.3 Agency Provider Type for Transportation For All Supported Employment Models

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Home and Community Based Services Waiver service provider for Supported Employment, or an individual providing support under authorized Consumer Directed Services.

32.10.12.4 Policy and Procedure for Transportation for Day Habilitation and Supported Employment Modules (One-to-One, Intensive, Follow Along, Mobile Work Crew/Enclave)

Policy

BCSS NOW pays a flat per diem for transportation when day habilitation and/or supported employment modules have been provided for the recipient. There are two separate rates. One rate is for regular transportation, and the other rate is for wheelchair transportation. The rate(s) is for a one time, round trip per day. Round trip is defined as transportation from the recipient's place of residence and return to the recipient's place of residence. Any transportation provided during the day from job site to job site or other trips is included in the one flat rate per day.

Procedure

- At the time of the development of the CPOC, if the recipient is in need of supported employment modules, and/or day habilitation, the transportation will be added to the CPOC.

- The case manager should check the appropriate transportation box in **Section VI, Identified Services, Needs, and Supports**, on Page 8 of 16 of the NOW CPOC and identify whether the transportation is regular or wheelchair.

- The case manager should identify in **Section VII, Typical Weekly Schedule**, on Page 9 of 16 of the NOW CPOC the times that transportation will be provided.
- The case manager should identify in **Section IX (A) CPOC Requested Waiver Services (Budget Sheet) – Typical Weekly and Alternate Schedule** on Page 11 of 16 of the NOW CPOC the transportation service provider's name, the appropriate transportation service procedure code, the transportation service type, and identify the days of the week the transportation will be provided and identify the total weekly number of transportation units of service.
- The case manager should identify in **Section IX (B) CPOC Requested Waiver Services (Budget Sheet)** on Page 12 of 16 of the NOW CPOC the transportation service provider's name, the transportation provider's number, the transportation service type, the transportation procedure code number, the typical weekly number of units of transportation, the cost/rate per unit for the transportation, total typical weekly costs for transportation, the number of weeks in CPOC year for transportation and the total typical annual weekly costs for the transportation.
- The case manager should complete the other needed services on the CPOC according to the instructions and submit to the BCSS Regional Office for approval.
- BCSS Regional Office will review the CPOC to assure that either a supported employment module and/or day habilitation services are listed on the CPOC prior to approving transportation.
- Once the BCSS Regional Office approves the CPOC the transportation services can begin.

32.10.13 EMPLOYMENT RELATED TRAINING
(Habilitation, Support Employment - HIPAA Code Name)

These are services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16and 71), and based on need.

Employment Related Training services consists of paid employment for recipients 18 year-old or older for whom competitive employment at or above the minimum wage is unlikely, and who because of their disabilities need intensive ongoing support to perform in a work setting.

Services are aimed at providing recipients with opportunities for employment and related training in work environments in accordance with U.S. Dept. of Labor regulations and guidelines, one to eight hours a day, one to five days a week at a commensurate wage in accordance with applicable regulations and guidelines. Services also include related training designed to improve and/or maintain the recipient's capacity to perform productive work and function adaptively in the work environment. Payment for these services includes transportation in the rate and the requirement the provider develops an individualized service plan.

Employment related training services begin when the recipient arrives at the employment related training site and the employment related training activities contained in the individualized plan of care begin.

Employment Related Training Services include but are not limited to:

- A recipient receives assistance and prompting in the development of employment related skills. This may include assistance with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, and behavioral support needs and any medical task, which can be delegated.
- A recipient is employed at a commensurate wage at a provider facility for a set or variable number of hours.
- A recipient observes an employee of an area business to obtain information to make an informed choice regarding vocational interest.
- A recipient is taught to use work related equipment.
- A recipient is taught to observe work-related personal safety skills.
- A recipient is assisted in planning appropriate meals for lunch while at work.
- A recipient learns basic personal finance skills.
- A recipient and, as appropriate, his/her family receive information and counseling on benefits planning and assistance in the process.

32.10.13.1 Special Limitations

- To bill for this service, the recipient and the employment related training worker must be present.
- The recipient must be 18 years of age or older.

- Cannot exceed 8,320 ¼ hour units per recipient per CPOC year.
- Limited to 8 hours a day, 5 days a week.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Supported Employment Models (one-to-one, follow along, mobile work crew/enclave), Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Community Integration Development, or Center-Based Respite.
- The recipient may be paid by the employment related training provider for engaging in this service, according to Federal regulations.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction for his or her own waiver needs.

32.10.13.2 Agency Provider Type

Providers must be licensed by the Department of Social Services as an Adult Day Care Provider and enrolled Medicaid Home and Community Based Services Waiver service provider of employment related training.

32.10.14 PROFESSIONAL SERVICES

These professional services are limited to psychological services, social work services, and nursing services. Professional services are direct services to recipients 21 years-of age and older, based on need, and specified in the BCSS approved Comprehensive Plan of Care.

They are to be used only when the services are not covered under the Medicaid State Plan. The purpose of these services is to increase the recipient's independence, and his/her participation and productivity in the home, work, and community. Service intensity, frequency, and duration will be determined by the recipient's needs. Professional services must be delivered in the recipient's presence and be provided based on the BCSS approved CPOC and under an individualized service plan.

Professionals must possess a valid Louisiana license in the specific area in which they are providing services and have at least one year of experience post licensure.

Professional services are limited to $1,500 per recipient per CPOC year for the combined range of professional services.

32.10.14.1 Description of Services

Professional services are limited to the following:

- **Psychological Services - (Psychosocial Rehabilitation Services - HIPAA Code Name)**

  Psychological services are direct services performed by a licensed psychologist, (Ph.D.) as specified by State law and licensure. These services are for the treatment of behavioral or mental conditions that address personal outcomes and goals desired by the recipient and his or her team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with Mental Retardation or Developmental Disabilities.

The service must be outlined in the BCSS approved CPOC. Psychology services include:

- Counseling (a variety of techniques and procedures used by the therapist, i.e., structuring and reinforcement, social modeling, functional activities, etc.)
- Behavior evaluation for the purpose of therapy
- Ongoing therapeutic support
- Ongoing behavior training for staff and/or families
- Administering and interpreting tests and measurements within the scope of practice of behavior therapy
- Administering, evaluating, and modifying treatment and consulting within the scope of practice of behavior therapy
- Adapting environments specifically for the recipient

- **Social Worker Services - (Psychosocial Rehabilitation Services – HIPAA Code Name)**

  Social worker services are highly specialized direct counseling services furnished by a Licensed Clinical Social Worker (LCSW).

  Services are highly specialized and designed to meet the unique counseling needs of recipients with Mental Retardation and Development Disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address those personnel outcomes and goals listed in the BCSS approved CPOC.

- **Nursing Services - (Psychosocial Rehabilitation Services - HIPAA Code Name)**

  Nursing services are medically necessary direct services provided by a Licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services will be outlined in the BCSS approved CPOC and as ordered by a physician. Direct services may address health care needs related to prevention and primary care activities, treatment, and diet. Services must comply with the Louisiana Nurse Practice Act.

Reimbursement will be for the direct service provided directly to the recipient performed by a nurse only, and not for the supervision of a nurse performing the hands-on direct service.

Professional services may be performed the same day as professional consultation. They may not be provided or billed for at the same hours on the same day.

32.10.14.2 Requirements for Direct Psychological Services, Social Work Services, and Nursing Services

Providers of these services must:

- Perform an initial evaluation to assess the recipient's needs for services;
- Develop an individual service plan;
- Implement the recipient's therapy plan in accordance with appropriate licensing and certification standards;
- Within 10 working days, complete progress notes for each session, and provide these notes to the designated case manager every three months, or as specified in the BCSS approved CPOC;
- Maintain current and past records and make them available upon request to BCSS, service providers, case management agency, the Centers for Medicare and Medicaid Services (CMS), and/or Legislative Auditors;
- Bill for services based on a BCSS approved CPOC and Prior Authorization, only for services rendered;
- Comply with DHH/BCSS standards for payment, MAPIL, HIPAA, ADA, and licensing requirements.

Non-Billable Activities of the Provider:

- Friendly visiting, attending meetings.

- Time spent on paperwork or travel.
- Time spent writing reports and progress notes.
- Time spent on general staff training not related to training for the natural or paid support regarding the recipient's program plan. Time spent on billing of services.
- Other non-Medicaid reimbursable activities.

32.10.14.3 Special Limitations

- To bill for this service, the recipient must be present when the professional rendered the service.
- The recipient must be 21 years or older.
- $1,500 cap per recipient per CPOC year for all professional services.
- Must be billed in 15-minute increments.
- A recipient could receive two or more professional services on the same day; however, these two professional services will not be authorized at the same time.
- Professional services and professional consultations may be performed on the same day but shall not be provided or billed for at the same hours on the same day.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Transportation for day habilitation, Supported Employment models, Transportation for supported employment models, Employment Related Training, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Community Integration Development, Skilled Nursing Services, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.14.4 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled Medicaid Home and Community Based Services Waiver service providers of Personal Care Attendant, Supervised Independent Living, or Home Health Services as licensed by the Department of Health and Hospitals.

Each professional rendering service(s) must possess a valid Louisiana and have one-year experience in their field of expertise post licensure.

The professional could either be employed or contracted with the SIL, PCA or Home Health agency to provide this service

Agencies enrolled as both SIL and PCA provider types shall bill these professional services. Under there PCA number in accordance with the fiscal intermediary requirements. Agencies enrolled, as only SIL or Home Health would bill under their SIL or Home Health provider number.

32.10.15 PROFESSIONAL CONSULTATION

These professional consultation services are limited to psychological consultation services, social work consultation services, and nursing consultation services.

Professional consultation services are consultative services to recipients 21 years-of age and older, based on need, and specified in the BCSS approved Comprehensive Plan of Care. They are to be used only when the services are not covered under the Medicaid State Plan.

The purpose of these services is to evaluate, develop programs, and train natural and formal supporters to implement training or therapy programs, which will increase the recipient's independence, participation, and productivity in his/her home, work, and community.

These services are not meant to be long-term, on-going services, but instead are normally meant to be short-term or intermittent to develop critical skills which may be self-managed by the recipient or maintained by natural and formal supporters.

The recipient must be present during all aspects of the consultation in order for the professional to bill and receive payment for this service. Service intensity, frequency, and duration will be determined by recipient need. These services may include assessments and periodic reassessments.

Professional consultations services are limited to $750 per recipient per CPOC year for combined range of professional consultation services. All professionals must possess a valid Louisiana license to practice in their area of expertise and have one-year minimum experience post licensure and be contracted or employed by the PCA, SIL, or Home Health Agency.

32.10.15.1 Description of Services

Providers must be licensed in the specific area in which training or consultation is being offered. Professional consultation services will include the following:

- **Nursing Consultation - (Skilled training and development - HIPAA Code Name)**

  Nursing consultation services are provided by a licensed registered nurse regarding those medically necessary nursing services ordered by a physician that exceed the service limits for home health services under the Medicaid State Plan and do not meet the skilled nursing criteria for NOW. Nursing consultation services must be on the BCSS-approved CPOC. Services must comply with the Louisiana Nurse Practice Act. Consultation services may address health care needs related to prevention and primary care activities.

- **Psychological Consultation - (Skilled training and development - HIPAA Code Name)**

  Psychology consultation is evaluation and education performed by a licensed psychologist (Ph.D.) as specified by state law and licensure. These services are for the treatment of behavioral or mental conditions that address personal outcomes and goals desired by the recipient and his/her team.

  Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with Mental Retardation or Developmental Disabilities.

  Consultation provides the recipient family, care givers, and team with information necessary to plan and implement plans for the recipient. This services must be outlined in the BCSS approved CPOC.

- **Social Worker Consultation (Skilled training and development - HIPAA Code Name)**

  Social Worker consultation services are highly specialized consultation services furnished by a Licensed Clinical Social Worker (LCSW). These services are highly specialized and designed to meet the unique counseling needs of recipients with Mental Retardation and Development Disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address those personal outcomes and goals listed in the BCSS approved CPOC.

32.10.15.2 Requirements for Direct Psychological Consultation, Social Work Services, Nursing Services

These providers shall:

- Perform an initial evaluation to assess the recipient's needs for environmental services that can be carried out by a paraprofessional or family member;
- Develop an individual service plan;
- Educate the care giver on the recipient's therapy plan, in accordance with appropriate licensing and certification standards;
- Within 10 working days, complete progress notes for each consultation session, and provide these notes to the designated case manager every three months, or as specified in the CPOC;
- Maintain current and past records and make them available to BCSS, agency representatives, CMS, or legislative auditors;
- Bill for consultation based on a BCSS approved CPOC and Prior Authorization only for services rendered (all other activities are built into the rate and are identified as non-contractual activities);
- Comply with DHH/BCSS standards for payment, MAPIL, HIPAA, ADA, and licensing requirements
- A formal Behavioral Support plan is needed when the recipients' behavior creates problems/concerns with daily life situations; when the recipient's behavior puts himself or herself or others at risk; when other restrictive methods are utilized; when psychotropic medications are used for behavioral concerns; and/or when less restrictive methods of behavioral support have proved ineffective.

Non-Billable Activities of a Provider:

- Friendly visiting, attending meetings,
- Time spent on paperwork or travel,
- Time spent writing reports and progress notes,
- Time spent on staff/provider training,
- Time spent on billing of services, and
- Other non-Medicaid reimbursable activities.

32.10.15.3 Special Limitations

- To bill for this service, the recipient and the professional rendering consultation the service must be present.
- The recipient must be 21 years or older.
- $750 cap per recipient per CPOC year, for all professional consultation.
- Must be billed in 15-minute increments.
- Two or more professional consultations could be received by a recipient on one day; however, these two professional consultations will not be authorized at the same time.
- Professional services and professional consultations may be performed on the same day but shall not be provided or billed for at the same hours on the same day.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Transportation for day habilitation, Supported Employment models, Transportation for supported employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Skilled Nursing Services, Community Integration Development, or Center-based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.15.4 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled in Medicaid Home and Community Based Services Waiver service providers of Personal Care Attendant, Supervised Independent Living, or Home Health Services as licensed by the Department of Health and Hospitals. Each professional rendering consultation service(s) must possess a valid Louisiana license and have one-year experience in their field of expertise post licensure.

The professional could either be employed or contracted with the SIL, PCA or Home Health agency to provide this service.

Agencies enrolled as both SIL and PCA provider types would bill this service under their PCA number. Agencies enrolled as only SIL or Home Health would bill under their SIL or home health provider number.

32.10.16 PERSONAL EMERGENCY RESPONSE SYSTEMS

(Emergency Response System, Installation and Testing Only - HIPAA Code Name)
(Emergency Response System, Maintenance, HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, a Personal Emergency Response System (PERS) is a rented electronic device connected to the recipient's phone, which enables a recipient to secure help in an emergency. The recipient may wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.

Personal Emergency Response Systems (PERS) services are limited to those persons who:

- Live alone, or
- Live alone without the benefit of a natural emergency backup system, which would include care givers (paid and non-paid), and who would otherwise require extensive routine IFS services or other NOW services and due to cognitive limitations, need support until educated on the use of PERS and the direct support is phased-out. This phase out plan must be addressed in the BCSS approved CPOC, or
- Have older or disabled care givers, or
- Are not equipped with other communication systems to summon emergency assistance.

32.10.16.1 Special Limitations

- Coverage of the PERS is limited to the rental of the electronic device.
- The monthly rental fee, regardless of the number of units in the household, must include the cost of maintenance and training the recipient how to use the equipment.
- Reimbursement will be made for a one-time installation fee for the PERS unit.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.16.2 Agency Provider Type

Providers must be enrolled in Medicaid Home and Community Based Services Waiver program as a service provider of PERS.

32.10.17 SKILLED NURSING SERVICES

(RN services - HIPAA Code name) - (LPN/LVN services - HIPAA Code Name)

Based on need and specified in the BCSS approved CPOC, Skilled Nursing Services are medically necessary nursing services ordered by a physician and provided to a medically fragile recipient in or outside of the recipient's home. Skilled Nursing Services will not be paid for in hospitals and/or other institutional settings. Skilled Nursing Services are designed to meet the needs of the recipient, to prevent institutionalization, and teach the recipient and/or family necessary medical or related interventions, such as medication management, as ordered by a physician. All Medicaid State Plan Services available to the recipient must be utilized before accessing this service. Skilled nursing services will be provided by a licensed, enrolled home health agency using Licensed Nurses, to 21 year-old or older recipients who require skilled nursing services and who meet the medically fragile criteria as defined below.

32.10.17.1 Skilled Nursing Services Medical Criteria

- Recipients diagnosed with a chronic disease which the disease requires added vigilance by a licensed nurse to provide prevention, monitoring and assessment in order to management the acuity of the disease and reduce the frequency of acute and emergency services. Chronic conditions requiring skilled nursing services include: insulin dependence; unstable or uncontrolled diabetes; insufficient respiratory capacity requiring use of oxygen therapy, a ventilator and/or tracheotomy; hydration, nutrition, and/or medication via a gastronomy tube; severe muscular-skeletal conditions/non-ambulatory status that require increased monitoring and/or the treatment of decubitus; kidney failure requiring dialysis; cancer requiring radiation/chemotherapy; and end-of-life care not covered by hospice services.

OR

- Recipients with chronic disease process who require life-sustaining equipment necessary to sustain, monitor, and treat a recipient to ensure sufficient body function. Such medical equipment may include: a ventilator, a suction machine, pulse oximeters, apnea monitors, or nebulizers.

- This category may also include recipients who require the admission of medications, which by law must be administered by a licensed nurse via mediports/central lines/intravenous therapy. The use of the equipment referenced does not have to be continuous, but must be medically necessary and life sustaining as documented by the primary care physician.

AND

- Skilled Nursing services must be included in the recipient's BCSS approved CPOC, have a physician's order, a physician's letter of medical necessity, 90-L and 485, an individual nursing service plan, a summary of medical history, and the skilled nursing checklist.

32.10.17.2 Requirements for Skilled Nursing Services

Provider agencies of Skilled Nursing Services shall:

- Assure that services are delivered by Licensed Nurses licensed by the State of Louisiana, and who have at least one year of Medical-Surgical experience managing the chronic condition the recipient has.
- Inform the case manager immediately of the providers' inability to staff according to the Recipients Nursing Service Plan.
- Develop and implement an Individual Nursing Service Plan as noted in the BCSS approved Comprehensive Plan of Care (CPOC) in conjunction with the recipient's physician, planning team and the case manger in a manner identifying and fulfilling the Waiver recipient's specific needs in a cost-effective manner.
- Provide the case management agency with physician-ordered changes every 60 days regarding the NOW Waiver recipient's health status and health needs.
- Follow all NOW Waiver requirements and State and Federal rules and regulations for licensed home health agencies and nursing care. Must obtain authorization; follow Home Health Agency requirements for assessment, supervision, documentation, and physician authorization.
- Complete progress notes for each treatment, assessment, intervention, and critical incident, and report any NOW Waiver recipient's non-compliance with or refusal of the established Individual Nursing Service Plan, and provide these notes to the designated case manager every three months, or as specified in the BCSS approved CPOC.
- Maintain current and past records and make them available to BCSS, agency representatives, CMS, or legislative auditors.
- Bill for prior authorized services rendered based on a BCSS approved CPOC.
- Comply with DHH/BCSS standards for payment, MAPIL, HIPPA, ADA, and licensing requirements.
- The home health nurse and the case manager **shall** communicate frequently. Monthly telephone contact is required to allow the case manager to determine if further planning is required.

32.10.17.3 Special Limitations

- To bill for this service, the recipient and the nurse providing the skilled nursing service must be present.
- The recipient must be 21 years or older.
- Providers must be bill in 15-minute increments.
- All Medicaid State Plan services must be utilized before accessing this service.
- Skilled Nursing Services cannot be provided or billed for at the same hours on the same day as; Transportation for day habilitation, transportation for supported employment models, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support- Day and Night, Shared Supports- Day and Night, Community Integration Development, or Center-Based Respite.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Request for 12 hours or less per day can be approved at the BCSS Regional Office.
- Requests for 13 hours or greater per day or more must be forwarded to the BCSS State Office for review of the Medical Review Panel. The Medical Review Panel consists of at a minimum, a Medical Doctor and a Registered Nurse.
- A request to increase the number of skilled nursing hours per day above the number of hours already approved requires the primary care physician to document the medical change(s) of the client necessitating the increase in the request for skilled nursing services.
- When there is more than one recipient in the home receiving skilled nursing services, services maybe shared and payment must be coordinated with the Service Authorization system and each recipient's CPOC.

32.10.17.4 Agency Provider Type

Providers must be licensed by the Department of Health and Hospitals and enrolled Medicaid home and community based services Waiver service provider of Home Health.

32.10.17.5 Home Health Agency Standards and Procedures

The Bureau of Community Supports and Services requires certain standards to be maintained by Home Health agencies providing skilled nursing services:

- The Home Health agency must be licensed and enrolled to provide Home Health services in the State of Louisiana and meet all Minimum Standards for Home Health Agencies. The agency must also be an enrolled provider of Medicaid-reimbursed skilled nursing services.
- It is the responsibility of the Home Health agency to ensure that all nurses employed to provide skilled nursing services are either registered nurses or licensed practical nurses holding a current Louisiana Board of Nursing license, with a minimum of one year of supervised nursing experience in providing skilled nursing services in a community setting to recipients who meet the medically fragile criteria.
- The agency must render services to the recipient as ordered by the primary care physician as reflected the recipient's BCSS approved Comprehensive Plan of Care and within the requirements of the Louisiana Nurse Practice Act. For the purpose of this policy, nursing assessments, nursing care planning, and revisions of care planning are consistent with CMS Forms 484, 485, 486, and OASIS and shall be used by the Home Health Agencies providing skilled nursing services.

Documents to be collected and submitted to the case management agency include:

- Primary Care Physician's Order for Skilled Nursing Services must be signed, dated, and contains the number of hours per day of skilled nursing services and the duration of the skilled nursing services necessary. This must be updated at least every 60 days. A copy of the physician's approval shall be sent to the case management agency prior to expiration of the previous approval to ensure continuation of services. This letter must be included at the time of the recipient's annual CPOC.
- Primary Care Physician's Letter of Necessity for Skilled Nursing Services must be on the Physician's letterhead, listing and identifying all nursing duties to be performed by the nurse, and stating the current medical condition of the recipient warranting skilled nursing services.
- Primary Care Physician's 90-L.
- Summary of the recipient's Medical History - must include a recent (within one year) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) extended home health approvals and other specific service needs which must be based on documented record review.
- Form 485 completed by the Home Health Agency identifying the skilled nursing service needs.
- Prior Authorization will not be released if the physician's orders are not submitted as required.

- Any changes in the recipient's nursing service needs must be reported to the case manager. If necessary, the case manager will call an ID Team meeting for CPOC review planning and any needed revision. (This includes changes, which increase skilled nursing services in excess of 12 hours per day). The Home Health Agency, in accordance with their regulations, must revise their Individual Nursing Services Plan every 60 days. However, it is not necessary to revise the CPOC every 60 days unless there is a change in the recipient's medical condition, which requires the need for additional skilled nursing services or the recipient requests, a change.
- Changes in the Individual Nursing Service Plan must be approved by the primary care physician and reflect the physician's orders for the skilled nursing service.
- Communication between the case manager and the home health agency nurse should be no less than monthly.
- The Home Health agency must provide an orientation to waiver services and assure that the licensed nurse adheres to the BCSS Critical Incident Reporting policy.
- The Individual Nursing Service Plan must be current and available in the recipient's home at all times.

32.10.17.6 Case Management Agency Procedures

- The case manager convenes the Interdisciplinary Team (ID Team) for a recipient who is medically fragile. This ID Team meeting must include the licensed home health nurse who is responsible for the development of the Individual Nursing Service Plan. The case management agency will not need to verify if the recipient has exhausted his/her home health services under the Medicaid State Plan as skilled nursing services through the NOW waiver are in addition to these home health services.
- The CPOC must be developed and include strategies and interventions necessary to assure the medically fragile recipient's health and safety. Skilled Nursing Services must meet the following requirements:
  - Ordered by the recipient's primary care physician
  - Approved by the primary care physician
  - Medically necessary to support the recipient in the community; and
  - Set forth the coordination of all services including the skilled nursing service included in the CPOC

- Set forth the use of natural supports, when available, to compliment the skilled nursing service

- The CPOC is submitted to the BCSS Regional Office for approval following the requirements outlined in the Case Management Services Provider Manual.
- Submit all documents collected by the home health agency, along with the CPOC, to the BCSS Regional Office.
- When changes in the recipient's nursing service needs are reported to the case manager, the case manager may call an ID Team meeting for CPOC revision and planning. This includes changes, which increase skilled nursing services in excess of 12 hours per day. However, it is not necessary to revise the CPOC every 60 days unless there is a change in the recipient's medical condition, which requires the need for additional skilled nursing services or the recipient requests, a change. The physician's order for skilled nursing services must be updated every 60 days in accordance with home health agency requirements and a copy submitted to the case management agency.

- Quarterly Face to Face monitoring includes: Observing delivery of skilled nursing services, the recipient's health and safety needs, related skilled nursing needs and the recipient's progress towards personal outcomes.

32.10.17.7 BCSS State Office Responsibilities

- When a request for more than 13 hours per day or greater of skilled nursing services is received from the BCSS Regional Office, the NOW Waivers Manager will convene with the DHH/BCSS Designated Physician & Medical Review Team.

- When a request for consultation for 13 hours or more per day is received from the BCSS Regional Office, the NOW Waivers Manager will request review by the Medical Review Team.

- After the Medical Review Team reviews the documentation for skilled nursing services for 13 or more hours per day, the NOW Waivers Manager will notify the BCSS Regional Office of the decision.

32.10.17.8 Appeals

- Any recipient who disagrees with the decision reached concerning his/her request for skilled nursing services has the right to request a fair hearing/appeal.

- An appeal request may be submitted verbally or in writing specifically stating the reason(s) of disagreement with the BCSS decision to the BCSS Regional Office, BCSS State Office, or directly to the DHH Bureau of Appeals within 30 days from notification of denial of services must be within 10 days of denial to continue the existing approved services. The requested changes will not be in effect until the administrative law judge makes a decision.

32.10.18 SUBSTITUTE FAMILY CARE (Foster Care/Adult, HIPAA Code Name)

Substitute Family Care (SFC) is a stand-alone family living arrangement for recipients 18 years of age and older and the SFC "parents" assume the direct responsibility for the recipient's physical, social, and emotional well being and growth, including family ties.

This service provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law) provided in a licensed Substitute Family Care Home.

The total number of recipients (including persons served in the waiver) living in the home who are unrelated to the principal care provider cannot exceed three.

Payment for rendered services is dependent upon the prior authorization of the SFC services on the BCSS-approved CPOC and includes the development of an individual service plan.

32.10.18.1 Special Limitations

- To bill for this service, the recipient must be in the substitute family setting.
- Services cannot exceed 365 days a year.
- Payment does not include room and board.
- The SFC provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Immediate family members, who include mother, father, brother, sister, spouse or curator cannot be a substitute family care parent.
- SFC homes shall not be SIL living settings.

32.10.18.2 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled in Medicaid Home and Community Based Services Waiver service provider of Substitute Family Care, or an individual providing support under authorized Consumer Directed Service.

32.10.19 ONE TIME TRANSITIONAL EXPENSES; Life Time Limits (Community Transition waiver HIPAA Code name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Transitional Expenses are set-up expenses capped at $3,000 over an recipient's life time. The expenses cannot constitute payment for housing, rent or refundable security deposits.

The expenses are for recipients 18 years of age and up who make the transition from an ICF/MR to his/her own home or apartment in the community of their choice.

Own home shall mean the recipient's own place of residence and does not include any family members home or substitute family care home(s).

32.10.19.1 Description of Services

- Essential furnishings such as bedroom and living room furniture, table and chairs, window blinds, eating utensils, and food preparation items such as pots and pans;
- Moving expenses required to occupy and use a community domicile;
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.
- Can be used for non-refundable security deposits.

32.10.19.2 Services Exclusion

- Cannot be used for payment for housing or rent.
- Cannot be used for refundable security deposits.

32.10.19.3 Service Limitations

- Life time limit of $3,000 per recipient.
- Service authorization and transitional expenses are time limited

- Once a recipient has been approved for one time transitional expenses, and made purchases any additions must be requested by the recipient and must be submitted on a new TEPA form and authorized by the case manager and the BCSS Regional Office.

Additional request may be submitted up to 30 calendar days after the stamped date the BCSS Regional Office receives the 18-W in the event "last minute needs" are identified.

All billing is based on the BCSS approved TEPA authorization for which payment is being requested. The BCSS approved TEPA authorization must be completed within 60 calendar days after the BCSS Regional Office receives the 18-W in order for the reimbursements to be paid.

32.10.19.4 Procedure

When an individual has been offered an opportunity to participate in the NOW, it is the responsibility of the case manager that has been selected by the recipient transitioning from an ICF/MR into the community, to include as a part of the person centered planning process, a plan that shall include the transition expenses the individual will have as he/she moves into his/her own community residence. No TEPA funds will be disbursed without prior authorization of expenditures.

- The Transitional Expenses Planning and Approval (TEPA) form is the form the case manager will complete with input from the recipient and their circle of support reflecting the need for transitional expenses.

- The case manager will complete the TEPA form and forward it to the BCSS Regional Office along with the Comprehensive Plan of Care (CPOC) packet for review and pre-approval. The CPOC must have the one time transitional expenses included and the budget sheet reflecting the estimated TEPA cost. This is part of the pre-142 approval process for those transitioning out of an ICF/MR facility into the community. The purchasing process cannot begin until the TEPA is given pre-142 approval.

- Once pre-approval of the request is obtained from the BCSS Regional Office, the BCSS Regional Office will fax the pre-approved TEPA form to the Office for Citizens with Developmental Disability (OCDD) and the case manager. In no instance, will the date OCDD receive the pre-approved TEPA form be less than 10 working days from actual move date.

The case manager shall contact the transition expense coordinator at the Office for Citizens with Developmental Disabilities (OCDD) Office in Baton Rouge at:

Office for Citizens with Developmental Disabilities
P.O. Box 3117, Bin #21
Baton Rouge, Louisiana 70821-3117
Attention: Fiscal Section
Telephone 225-342-0095
Fax 225-342-8823

- OCDD will set up a transition expense record for each recipient.
- OCDD will utilize the pre-approved TEPA form to ensure that only the item/services listed are reimbursed to the designated purchaser. The recipient will identify the designated purchaser(s). The designated purchaser may be the participant, their authorized representative, the SIL provider, or the case manager. The case manager or their designee will work with the designated purchaser to obtain items pre-approved by BCSS on the TEPA form. The designated purchaser(s) are responsible for submitting the original receipts to the case manager within the allotted time frame. After purchases are made, the case manager will be responsible to:
    - Collect original receipts from the designated purchaser(s) and identify the designated purchaser(s) of the pre-approved item(s) to be reimbursed.
    - If the person or entity to be reimbursed is not already established as a state vendor, then a Form W-9 (Request for Taxpayer Identification Number and certification) must be completed.
    - Summarize all items purchased by the designated purchaser(s) on the NOW TEPA invoice form.
    - Inform the designated purchaser/entity to be reimbursed that the service authorization for purchase of pre approved/approved TEPA transitional expenses items is time-limited.
- BCSS Regional Office will review the purchased items with the recipient at the Pre-Certification Home Visit for approval.

  Payment will not be authorized until the BCSS Regional Office gives final CPOC approval upon receipt of the 18W. Upon receipt of the 18-W, the BCSS Regional Office will fax to OCDD Fiscal at 225-342-8823.

- If there are any differences between the approved estimated TEPA cost and the actual TEPA cost, then the case manager must submit a revised CPOC budget sheet to BCSS Regional Office with the actual cost for each item previously approved item noting the cost difference.
- The case manager will send the completed TEPA form with the actual costs to OCDD for verification after the pre-certification home visit. OCDD will review documents for completeness and compliance with the BCSS approved TEPA request.
- OCDD will send BCSS Regional Office the verified TEPA for Service Authorization.
- BCSS Regional Office will give final approval based on OCDD's verification of the actual expenditures on the approved TEPA form. BCSS Regional Office will fax back to the OCDD State Office the final approved TEPA form for maintenance in the OCDD payment record. BCSS Regional Office will fax the approved TEPA form to the BCSS PA contractor.
- Service authorization will be issued to OCDD for the actual cost of items as identified on the BCSS approved TEPA form. Any new items not on the original approved TEPA form will not be reimbursed.
- OCDD will bill the Medicaid fiscal intermediary under Procedure Code Z0636.
- Once payment is received from Medicaid for these expenses, OCDD will forward the reimbursement to the designated purchaser.
- Additional items not on the original request, must be requested by submitting a new TEPA form for authorization by the case manager up to 30 calendar days after the date the BCSS Regional Office receives the 18-W in the event "last minute needs" are identified. The same procedure outlined in steps 5 and 7 through 12 above will be followed for any additional requests.
- All billing based on the BCSS approved TEPA authorization for which payment is being requested must be completed within 60 calendar days after the stamped date the BCSS Regional Office receives the 18-W in order for the reimbursement to be paid. The case manager would follow the same steps outlined above regarding submitting of invoices for reimbursement.
- OCDD will maintain documentation including each recipient's individual TEPA form with original receipts and record of payments to the authorized purchaser for the recipient. This documentation is for accounting and monitoring purposes.

32.10.19.5 Agency Provider Type

The Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD) will coordinate the appropriate entities for the provision of these services.

32.10.20 TRANSITIONAL PROFESSIONAL SUPPORT SERVICES (Crisis Intervention Services - HIPAA Code Name)

Based on need and specified in the BCSS approved CPOC, Transitional Professional Support services is a system using specialized staff and resources to intervene and stabilize a situation caused by any severe behavioral or medical circumstance that could result in loss of a current community-based living arrangement.

32.10.20.1 Description of Services

These services are available for recipients 3 years of age and up who have met all of the following criteria:

- A developmental disability or one or more concurrent diagnosis:
    - Mental health diagnosis of Autism or other pervasive developmental disorder
    - Transitioned or who are in the process of transitioning out of public Developmental Centers
    - A history of recurrent challenging behaviors that risk injury to self or others, or result in significant property damage
    - A documented need for Professional Services and/or Professional Consultation above the limits of Professional Services and/or Professional Consultations, or services available in the Medicaid State Plan, with a statement of necessity by the treating psychiatrist/psychologist and an individual service plan in the recipient's BCSS approved CPOC.
    - All Medicaid State Plan services must be utilized before accessing this service.

OR

- An recipient with an acute illness or injury in which the acute condition process requires an added vigilance by a licensed nurse to provide surveillance, early identification and treatment of disease symptoms to avert and/or delay the

consequence of advanced complications of the acute condition, thereby limiting the likelihood of a permanent debilitation state (such acute conditions may include trauma resulting in amputation of a limb, or care required after major surgeries)

AND

- The need exists with supporting documentation from a medical doctor, including:
    - A letter of medical necessity,
    - A physician's order, and
    - An individual nursing service plan.
- All Medicaid State Plan services must be utilized before accessing this service.

32.10.20.2 Special Limitations

- This service is limited to recipients who have transitioned out of state-operated Developmental Centers, and who have reached the $750 CPOC year cap for Professional Services and the $1,500 CPOC year cap Professional.
- Cannot be provided or billed for at the same hours on the same day as Day Habilitation, Transportation for day habilitation, Supported Employment models, Transportation for supported employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Community Integration Development, Skilled Nursing Services, or Center-based Respite.
- The provider shall not bill the fiscal intermediary for this service if the recipients have chosen Consumer Direction for their own waiver needs.

32.10.20.3 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled in Medicaid Home and Community Based Waiver service provider of Personal Care Attendant, Supervised Independent Living, or Home Health Services.

Home health agencies are licensed by the Department of Health and Hospitals. Each professional rendering service must possess a valid Louisiana licensed to practice in their field and a minimum of one-year experience in their field post licensure. The professional can either be on contracted or employed by the PCA, SIL or home health agency.

Agencies enrolled as both SIL and PCA provider types would bill this service under their PCA number. Agencies enrolled, as only SIL or Home Health would bill under their SIL or Home Health provider number.

An agency that fulfills this role must possess specialized staff and resources to intervene in and stabilize a situation caused by any severe behavioral or medical circumstance that could result in loss of a current community-based living arrangement.

32.10.20.4 Process to Access Transitional Professional Support Services

- The process to access transitional professional services would begin with the recipient or family making a request to the case management agency regarding the type service that is needed once professional Support or Consultation Services is exhausted or is expected to be exhausted with in the quarter.
- The case management agency would submit a revision to the CPOC that reflects the need for the transitional professional support services.
- The request should be based on recipient's needs and reflected in the results of the support team meeting
- Should be based on the recipient's needs and the result of the support team meeting.
- Necessary documentation of the need for theses services as outlined in the description of services for Transitional Professional Support Services must be attached to the CPOC Revision.
- Documentation should include:
    - A full description of need.
    - A history leading up to the need
    - A summary of the progress or lack of progress or regression related to the professional service consultation received.
    - A statement of medical necessity by treating Psychiatrist, Psychologist or Medical Doctor; Individual Service Plan with plan for review no less than every 90 days.

- The case management agency would send the CPOC revision and supporting documentation to the BCSS Regional Office.
- The BCSS Regional Office would review the revision request and act on it, by either approving, requesting additional information or disapproving.'
- The BCSS Regional Office would notify the case manager of the final determination of the CPOC revision request.
- In order for Transitional professional support services to be reimbursed by Medicaid, services cannot begin before the revision to the CPOC has been approved and prior authorization received.

32.11 GENERAL RECORD KEEPING

In accordance with Standards for Participation, published, September 20, 2003, in the *Louisiana Register.* The service provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as defined by Centers for Medicare and Medicaid Services regarding records and documentation. The service provider shall maintain all records required by Medicaid, BCSS, and Department of Social Services – Licensing Bureau.

Failure to comply with record keeping requirements will result in one or more of the following: recoupment, loss of enrollment, or referral to Surveillance and Utilization Review Systems (SURS).
The service provider shall:

- Maintain a complete and separate record for each recipient served and shall include the following:
    - Planning meeting minutes;
    - CPOCs;
    - Service logs;
    - Billing records;
    - Progress notes;
    - Eligibility records; and
    - All other pertinent documents.
- Provide all case records and billing documents to BCSS as required for monitoring activities and investigations upon request on site or within two hours if records are stored off site.

- Maintain the following documents and provide them to the BCSS upon request:
    - Copies of the current approved CPOC, the current service plan and all CPOC revisions in the recipient's case record and in the recipient's home. The documents must be current and available;
    - Documentation of payroll and services delivered within a time period must agree. Documentation of services delivered within a pay period will be recorded in the recipient's home record;
    - Updated and implemented service plan, to meet the service changes warranted by CPOC revisions within five calendar days of receiving a copy of the approved CPOC revision;
    - A copy of the behavior support plan, if one is required, in the recipient's home.

- Maintain documentation to support that services were rendered as per the BCSS approved and service plan. The provider shall:
    - Maintain documentation of the day-to-day activities of the recipient via service logs and progress notes;
    - Maintain documentation detailing the recipient's progress towards his/her personal outcomes;
    - Maintain documentation of all interventions used to ensure the recipient's health, safety and welfare. Interventions may include, but are not limited to, medical, consultations, and environmental and adaptive interventions.

- Develop written policies and procedures relative to the protections of recipient's rights which include, but not limited to:
    - Human dignity/respectful communication;
    - Person-centered planning/personal outcomes;
    - Community/cultural access;
    - Right to personally manage his/her financial affairs, unless legally determined otherwise or he/she gives informed consent;
    - Right to refuse service treatment;
    - Civil rights, such as right to vote.

32.11.1 Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at each Regional Office. The agency must have sufficient space, facilities, and supplies to ensure effective record keeping.

- The provider must keep sufficient recipient records to document provision of services and compliance with Medicaid requirements.

- A separate record must be maintained on each recipient that fully documents services provided and receipt of remittance advice indicating payment for services.

  The provider must maintain sufficient documentation to enable DHH to verify that prior to payment each charge is due and proper as identified in the section of this manual. Re: Components of Recipient Records.

- 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. Records must be maintained and present and available upon request.

- Records shall document the date; time period (for services) and each authorized service provided. Records shall include progress notes concerning observation of the client's condition, progress or other pertinent information. A checklist is insufficient.

32.11.2 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.

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.***

32.11.3 Confidentiality and Protection of Records

Records, including administrative and recipient, must be secured against loss tampering destruction or unauthorized use. Must follow HIPAA, Medicaid's or Division of Administration's confidentiality regulations whichever are most stringent in each area of confidentiality or protection of records.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the recipients or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the recipients or their families. The wrongful disclosure of such information may result in the imposition by DHH/BCSS of whatever sanctions are available pursuant to Medicaid certification authority] or the imposition of a monetary fine and/or imprisonment by the U. S. Government pursuant to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The information may be released only under the following conditions:

- By court order, or;
- By the recipient's written, informed consent for release of information;
- When the recipient has been declared legally incompetent, the recipient 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, furnish a copy of information in a recipient's case record to the recipient or the recipient's personal representative.

However, the provider may deny access to the record if a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the recipient or another person;

- The provider may charge a reasonable fee (not to exceed the usual and/or customary fee for copying) for providing the above records to the recipient.
- A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge or the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted.

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

*Note: **Under no circumstances should providers allow <u>any</u> staff to take recipient's case records from the office.***

32.11.4 Review by State and Federal Agencies

Service providers must make all administrative, personnel, and recipient records available to BHSF/BCSS and appropriate state and federal personnel at all times of office operation.

Providers must always safeguard the confidentiality of recipient information and follow the HIPAA requirements and where more stringent, the Medicaid confidentiality regulation.

32.11.5 Administrative Files

The service provider's administrative files must include at a minimum:

- Documents identifying the governing body as required and defined by Department of Social Services - Licensing Bureau requirements,
- List of members and officers of the governing body, their addresses, and terms of membership,
- Minutes of formal meetings and bylaws of the governing body, if applicable,
- Documentation of the service provider's authority to operate under state law,
- Functional organizational chart which depicts lines of authority,
- All leases, contracts, and purchase-of-service agreements to which the service provider is a party,
- Insurance policies,
- Annual budgets, audit reports, and accounting records,
- 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-term 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 recipients 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 all accounting records.
- All fiscal and other records concerning services as they are subject at all times to inspection and audit by the Department of Health and Hospitals, the Legislative Auditor, and auditors of appropriate federal funding agencies.

32.11.5.1 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 service provider's 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) work-related references.
- If transporting a recipient, a valid driver's license for operating a vehicle and valid automobile insurance.
- Verification of professional credentials required to hold the employed 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 dated prior to delivery of service to the recipient and annually.
- Confidentiality training and agreement.

An employee must have 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.

32.11.5.2 Recipient Records

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

Progress notes must be of sufficient content:

- To reflect descriptions of activities, procedures, and incidents,
- To give a picture of the services and,
- To show progress, if any, toward outcomes and goals.

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

- "Called the recipient(s)" or
- "Supported recipient(s)" or
- "Assisted recipient(s)" or
- "Recipient is doing fine" or
- "Recipient had a good day" or
- "Prepared meals"

Checklists alone are not adequate documentation for progress notes.

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

32.11.5.3 Organization of Records, Record Entries, and Corrections

The organization of recipient records and location of documents within the record must be consistent among all records. Records must be appropriately abridged so that current material can be 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,
- Must be legible,
- In ink,
- Reviewed by the supervisor, if required, and
- If necessary, corrected using the legal method only

The legal method of correcting a document or entry 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.**

32.11.5.4 Components of Recipient Records

The recipient's case record must consist of the active recipient record and the agency's storage files or folders.

32.11.5.4.1 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 telephone 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, and
- 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 Freedom of Choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc., signed by the recipient.
- Complete individual service plan as specified in the *Services Section* of this manual signed and dated by the recipient and copies of all pertinent correspondence.
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified below.
- Reason for case closure and any agreements with the recipient at closure.
- Records should reflect the most current utilization of services up to six months. 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 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 relationship of the contact to the CPOC.

- Any additional documentation required for other services identified in service definition section.

32.12.5.4.2 Service Logs

Service logs are a chronology of events and contacts which supports justification for service authorization or payment of services. Service logs must reflect services 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 an audit trail:

- Name of recipient,
- Name of service provider and employee providing the service,
- Service provider 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, and
- Content and outcome of service contact

There must be case record entries corresponding to each recorded case management 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 BCSS approved CPOC.
- 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.
- Logs must be consistent with BCSS approved CPOC and Prior authorization.

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

32.11.5.4.3 Progress Notes

Progress notes are the means of summarizing activities, observations and progress toward meeting service goals in the CPOC. Progress notes and summaries must:

- Indicate the name of the recipient that was contacted, the location where the contact occurred, and what services rendered and/or activities 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, which may indicate a need for a reassessment and CPOC change.
- Be readable (including signature) and include the job title of the person making the entry and date.
- Be completed and signed at least monthly, preferably weekly, by the person providing the services or direct service agency staff.
- Be recorded more often, either daily or weekly, if there is either frequent activity or significant changes occurring in the recipient's service needs and progress.

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.***

When a case is transferred to another service provider or closed, a summary must also be entered in the recipient's record.

32.11.5.4.4 Table of Documentation of Documentation Schedule

SERVICE PROVIDERS				
WAIVER	SERVICE LOG/PAYROL L SHEET	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
NOW	At time of every activity	At time of every activity and at least monthly	At least every 90 days	Within 14 days of discharge

32.12 PROGRAM MONITORING

32.12.1 INTRODUCTION

The Department of Health and Hospitals has instituted a procedure in which the Bureau of Community Supports and Services will provide management, direction, and supervision of waiver services delivered to waiver recipients by case management agencies and direct service providers. Services offered through Louisiana's New Opportunities Waiver (NOW) are monitored to assure compliance with DHH policy as well as applicable state and federal regulations.

BCSS regional staff conducts on-site reviews of each provider agency contracted with DHH and/or enrolled as a provider of waiver services. These reviews are conducted to monitor the provider agency's compliance with DHH Provider Enrollment's participation requirements, Standards for Participation, continued capacity for service delivery, quality and appropriateness of service provision to the waiver group, and the presence of the Personal Outcomes as defined and prioritized by the recipients served.

In addition to licensing and reviewing enrollments, BCSS conducts bi-annual monitoring for 5% of waiver recipients plus recipient identified as High Risk. Bi-annual 5% monitoring focuses on the quality of services and supports provided by the case management agency and direct service provider.

Program monitoring reviews may include but are not limited to the following areas:

- Recipient's health, safety, and welfare.
- Services provided in accordance with approved CPOC.
- Recipient's access to needed services identified in the service plan.
- Quality of assessment and service planning;
- Appropriateness of services provided including content, intensity, frequency and recipient input and satisfaction.
- The presence of the personal outcomes as defined and prioritized by the recipient/guardian.
- Internal quality assurance/quality improvement activities.
- Billing practices.
- Compliance with Standards for Participation for Waiver Service Providers.

A service provider's failure to follow DHH/Medicaid policies and practices could result in administrative sanctions such as the provider's removal from Medicaid participation, a federal investigation, and possible prosecution in suspected cases of fraud.

32.12.2 Types of Review Conducted by BCSS

Types of reviews conducted by BCSS include the following:

- Annual licensure for case management agencies,
- Enrollment of waiver direct service providers,
- Annual 5% Sample plus High risk recipients (Quality Focus),
- Complaint investigations,
- Critical incident investigations,
- Mortality case reviews, and
- Consumer satisfaction interviews.

32.12.2.1 On-Site Reviews

On-site reviews are conducted by BCSS regional staff on no less than a semi-annual basis but may be more frequent as a result of complaint investigation, critical incident investigations, and/or consumer satisfaction surveys.

An on site review is scheduled with the case management agency, the direct service provider and the recipient. The on-site reviews are conducted by BCSS Regional Monitor Teams.

In some instances, other state agencies may participate as part of the Monitoring Team (such as representatives from Louisiana's Adult, Child or Elderly Protection Services, representatives from the Office for the Citizens with Developmental Disabilities, and/or representatives from the Department of Education.

32.12.2.2 Case Management Agency Review

Licensure reviews are performed for initial licensing and annually thereafter. Licensing reviews are done in conjunction with the monitoring activities to the extent possible.

(Refer to Case Management Manual for additional information related to licensing of case management agencies by BCSS.)

Licensure Reviews include:

- A review of administrative records,
- Personnel Records,
- Training Records, and
- Other agency documents.

All attempts at scheduling annual re-licensing reviews will be made at the same time of the monitoring site visit prior to the expiration of the license. Administrative and personal record reviews will be conducted on initial licensing and license renewal, but may be included in the 5% monitoring if needed to substantiate findings of deficient practices.

In addition, administrative procedures, and record reviews, personnel and training records reviews may be required during complaint or critical incident investigations.

Failure to respond promptly and appropriately to the BCSS monitoring questions or findings may result in administrative sanctions according to Section 10 of this manual or liquidated damages and/or recoupment of payment.

32.12.2.3 Service Provider Reviews

Service providers are reviewed for initial enrollment as a waiver service provider and annual re-enrollment thereafter. Enrollment reviews include administrative procedures and records review, personnel records review, training records review, quality assurance activities, and recipient records review. Re-enrollment reviews are conducted in conjunction with the semi-annual monitoring review to the extent possible. Service providers may also be reviewed in conjunction with complaint investigations and/or critical incidents investigations.

32.12.2.4 Personnel Record Review

The personnel records review includes review of employees' file for driver's license (if driving is part of the job description), proof of age, criminal background checks, and orientation/training records for compliance with minimum Standards for Participation (Rule, September 20, 2003).

32.12.2.5 Service Provider Staff Interviews

Service provider agency staff interviews are conducted to ensure that case managers, direct service providers, and all supervisors meet the following staff qualifications:

- Experience
- Skills
- Staff coverage
- Supervisor-case manager ratio
- Caseload/recipient assignments
- Supervision documentation and,
- Other requirements as stated in the Standards for Participation.

32.12.2.6 Recipient/Guardian/Authorized Representative Interviews

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

- A representative sample (2% sample of the total number recipients served) by each provider agency;
- 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 case managers, case manager supervisors and other employees of the case management provider.

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

32.12.2.7 Recipient Record Review

Record reviews are performed at the case management agency and service provider agency to evaluate the quality of services and supports delivered to waiver recipients and to assure services are rendered according to the recipient's CPOC. The primary focus is placed on the outcomes to the waiver recipient.

Recipient's 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 recipient to attain or maintain the desired personal outcomes. The case record must indicate how these activities are designed to accomplish desired personal outcomes or how these activities are associated with personal outcome measures 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.

32.12.2.8 Monitoring Protocol

BCSS Regional Monitoring Team will monitor service providers for compliance with the Standards for Participation (Rule, *Louisiana Register*, September 20, 2003) with the option to expand/extend the survey if substantial non-compliance or the suspicion that substantial non-compliance exists.

32.12.2.9 Focus Review for Core Standards/Case Management Requirements

Core provider standards or core case management requirements are those determined to be the minimum compliance requirements that must be met by all waiver provider agencies. The core requirements for case management agencies are found in the licensing rule, September 20, 1994.

- The monitor reviews the clinical records and interviews agency staff to determine compliance with core standards or core case management requirements.

- If the provider agency is determined to be out of compliance with the core standards/core requirements, the monitors shall decide to extend the review to include all the standards for participation by waiver direct service providers, or conduct a full survey of the case management agency.
- The monitor may decide to expand the sample to identify a pattern of repeated deficiencies, if necessary to determine if an extended review is needed.

32.12.2.10 Partial Extended Review

The Partial Extended Review is primarily used in investigations of complaint and/or critical incident investigations. This review focuses on the provider standards or case management requirements relative to the allegations or the type of incident. This review shall include core standards or core case management requirements and may include any one or all-pertinent standards/requirements.

32.12.2.11 Full Reviews

Initial enrollment of direct service providers and initial licensure of case managers require a full review. Also, a full review shall be conducted as a result of the monitoring team's decision to extend the survey when significant number of deficiencies or deficiencies impacting the health, safety, or welfare of waiver recipients is identified.

32.13 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 case management or direct service provider agency's involvement of recipient input in the improvement in quality of service provision is also reviewed.

32.13.1 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 recipients served by each employee. The self-evaluation is also used for the agency to otherwise prepare for the on-site review by the BCSS 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 BCSS.

32.13.1.1 Components of the Provider Self –Evaluation

- The self-evaluation must include:
- Interviews by the case management agency or direct service provider agency with the recipients in the representative sample,
- Interviews by the case management agency and direct service provider agency with others who know the recipient best (family, friends, service and support providers, professionals, other members of the recipient's network of support), and
- A review of the case records of the recipients in the representative sample.

32.13.1.2 Self Evaluation Requirements

Findings of the self-evaluation completed by the case management 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.

32.13.1.3 Report of Self-Evaluation Findings

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

DHH-Office of the Secretary
Bureau of Community 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 recipients in the representative sample;
    - Assessment of the existence of required case record documentation in the representative sample; and
    - Written request or plan to acquire any needed technical assistance, training and/or support.

A sample of recipients included in the case record review is also surveyed to determine their satisfaction with the case management agencies and direct service providers. This part of the monitoring of the agency is to determine if the case management or direct service provider is meeting the needs of its recipients.

If the findings of the case management 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 describing how the agency will address issues with individual case managers or direct service staff to make systematic efforts to meet the personal outcome and case record documentation requirements.

32.13.1.4 Monitoring Report

Upon completion of the on-site review, the BCSS Quality Management staff discusses the preliminary findings of the review in an exit interview with appropriate staff of the case management or direct service provider agency. The BCSS 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 after the conclusion of the on-site visit.**

The monitoring report includes:

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

- Although the monitoring report has an educational component, any inappropriate reimbursement for possible recoupment action is identified in the report.
- The BCSS Quality Management staff will review the reports and assess any sanctions or liquidated damages as appropriate.

32.13.1.5 Corrective Action Report

The case management or direct service provider agency is required to submit a Plan of Correction (POC) to BCSS within **30 working days of the receipt of the report**. The Plan of Correction must address the following:

- What corrective actions will be accomplished for each citation, time lines for making the correction, and who within the agency is responsible for assuring the corrective action is taken;

- How other recipients, being served by the agency, who may have the potential to be affected by the deficient practice will be identified and correction action taken on their behalf;
- The measures that will be put into place or the systemic changes that will be made to ensure that the deficient practice does not recur; and

- How the corrective action will be monitored to ensure the deficient practice will not recur, such as addition to the agency's Quality Assurance/Quality Improvement Criteria.

- The provider agency is afforded an opportunity to rebut the BCSS monitoring findings through informal mediation.

- Upon receipt of the written Plan of Correction (POC), the BCSS 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 BCSS 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.

32.13.1.6 Mediation (Optional)

In the course of monitoring duties, an informal hearing process may be requested. The case management agency or service provider 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 case management agency or service provider agency and does not limit the right of the case management agency or service provider agency to a formal appeal hearing. In order to request the informal hearing, the case management agency or service provider agency should contact the Quality Management Administrator at

BCSS Quality Management Section
ATTN.: Informal Discussion
446 N. 12th Street
Baton Rouge, LA 70802
(225) 219 – 0643

Every effort will be made to schedule a hearing at the convenience of the case management agency or service provider agency. However, the request must be made within the time limit given for the corrective action recommended by the BCSS.

The case management agency or service provider agency is notified of time and place where the informal hearing will be held. The agency should be prepared to present all documentation supporting their position.

The BCSS Quality Management Program Manager solicits representation from other sections within the BCSS as well as other persons within BHSF to participate in the informal hearing process.

The BCSS Quality Management Program Manager facilitates the informal hearing. The case management agency or service provider agency is given an opportunity to present its case and to explain its disagreement with the monitoring findings, and/or to present new information. .

The case is discussed and the decision will be sent to the case management agency or service provider agency in a written response. There is no appeal of the informal hearing decision; however, the agency may appeal the original findings to the DHH Bureau of Appeals.

32.13.2 Fraud and Abuse

When BCSS Quality Management staff suspects patterns of abusive or fraudulent Medicaid billing, the service provider will be referred to the Program Integrity Section of the Medicaid Program for investigation. Specific information regarding fraud, abuse is found in Section 10 of this 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.

32.13.3 Immediate Jeopardy

Immediate jeopardy is a situation in which the provider's non-compliance with one or more standards of care and/or provider regulations has caused or is likely to cause serious injury, harm, impairment or death to the recipient.

These situations include physical abuse, sexual abuse, neglect and failure to protect the recipient from psychological harm, failure to protect the recipient from undue adverse medication consequences, failure to ensure adequate nutrition and hydration to the recipient, failure to practice standard precautions to protect from infection, and failure to plan for medical emergencies for recipients with known high risk medical conditions.

32.14 CONSUMER DIRECTION INITIATIVE SERVICE DESCRIPTION

32.14.1 Services Description

For many citizens with developmental disabilities and their families, a new approach for increasing their quality of life while addressing financial considerations will be offered as a waiver payment option in the Consumer Direction Initiative of the New Opportunities Waiver (NOW). This new initiative will be implemented through a three-year phase-in process with 250 participants. The data collected through the first three years of the phase-in will be used to create a basis for systems changes in Louisiana's Home and Community-Based Waivers. The DHH Regions involved in this initiative are 1, 2, and 9.

Participation in Consumer Direction is voluntary for the individual or his/her authorized representative. This initiative enables the participant and/or authorized representative the right to choose what services and/or supports best fit their individual needs through the person-centered planning process and where those services will be delivered. In addition, participating waiver recipients will have the right to hire, fire, train and schedule workers who are expected to provide the necessary direct services (e.g., personal assistant, home-health skilled nurse, contractor, social worker, psychologist, broker, etc). A required component of this option will be the use of fiscal agents to provide financial services and supports to participants who opt for the Consumer Direction Initiative. Fiscal agents will be contracted to provide functions on behalf of the participants, such as: training for participants and direct service providers regarding Consumer Direction; disbursement of public and private funds; monthly financial statements; audit reports; fiscal conduit; and generally be accountable for the individual's budget.

Case management services are utilized for supports brokerage; plan of care and individual budget development, advocacy, organizing the unique resources that the person needs, and for ongoing evaluation of the supports and services.

32.14.2 Service Authorization

BCSS Regional Office sends all approvals on Initial/Annual CPOCs and Revisions for prior authorization as follows:

- For initial CPOCs the cover page, budget pages, approval signature page, 18W, and 51NH are sent for authorization.
- For Revisions the approved budget sheets are to be sent for authorization.
- For Annual CPOCs the cover page, budget pages, approval signature page are to be sent for authorization.

Direct services with be authorized on the CPOC year begin date unless a later date is indicated on the CPOC budget page but will never be prior to the vendor payment begin date on the 51NH. Only those services in the BCSS approved CPOC shall be authorized.

Services shall not be reimbursed prior to the Vendor Payment Begin Date on the 51NH.

Authorizations will be issued in quarterly intervals directly to the provider and the last authorization will end on the CPOC end date.

Authorizations for annual CPOCs will be issued upon receipt of the annual CPOC.

32.15 BILLING RESPONSIBILITIES OF THE PROVIDER

The service provider should:

- Ensure all data provided to the case manager that is in the CPOC is correct.
- Immediately check their prior authorizations to see that all prior authorization for services match the approved services in the CPOC. Any mistakes that either under authorize or over authorize services shall be corrected to match the CPOC approved services. ONLY services in the BCSS approved CPOC shall be authorized.
- If there is an error in the CPOC, the service provider must go through the case manager to correct the CPOC and BCSS Regional Office must approve all changes.

Then the forms will go through the authorization process again.

- Before billing:
    - Review the Direct Service Worker timesheet to ensure the services delivered are in the BCSS approved CPOC and/or revisions
    - Bill only the amount of services that were documented as provided (as evidenced by the timesheets and case record notes) and ONLY if they are within the approved services in the CPOC make sure you bill with the correct span dates, authorization number, provider number, recipient # as indicated on the authorization
    - Reconcile all Remittance Advice's issued by Unisys with each payment.
    - Check each recipient billing to see that payment was given.

Service Providers have a one-year timely filing requirement under Medicaid regulations. This means that the service provider has up to one year to bill for prior authorized services delivered in accordance with the BCSS approved CPOC.

32.16 GLOSSARY

Abuse[1] - Inappropriate use of public funds by either providers or recipients, including practices which are not criminal acts and which may even be technically legal but still represents the inappropriate use of public funds.

Abuse[2] - 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)

Advocacy - Assuring that the recipient receives appropriate services of high quality and locating additional services not readily available in the community.

Agency -The legal entity enrolled to provide services under the approved Louisiana NOW. Both public and private agencies are eligible to provide waiver services.

Allegation of non-compliance - 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)

Appeal Rights - A due process system of procedures ensuring 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.

APS - Adult Protective Services.

Assessment[1]: A comprehensive process to collect, analyze and interpret information about an individual for the purpose of making decisions concerning the services and supports to address then person's needs.

Assessment[2]: - For purposes of case management, the process of gathering and integrating formal/professional and informal information concerning a recipient's goals, strengths, and needs necessary to develop a service plan.

Authorized Representative - The Consumer may select a representative (advocate) to speak on his/her behalf and who enters into the Consumer Direction Agreements on behalf of the waiver consumer.

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

Bureau of Community Supports and Services (BCSS) - The BCSS is responsible for directing the coordination and approval of all services and supports necessary for the planning development, and evaluation of all Home and Community Based supports and service offered through the Waivers and targeted populations approved by Centers for Medicare and Medicaid Services (formerly known as HCFA).

Case Management - 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 adapted from P.L. 100-203 (g)(2) and Section 4302A of the *State Medicaid Manual.* Case management is a necessary component in the management of services under this waiver, and provider agencies are licensed by BCSS. Case management, how ever, is not a waiver service.

Case Management-Supports Brokerage - Encompasses assessment, service planning, referral and monitoring services for the individual receiving waiver services.

Case Manager - Individual meeting qualifications as required by DHH who is employed by a qualified provider agency that provides case management services.

Centers 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. Previously named Health Care Financing Administration (HCFA).

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

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)

Confidentiality - The limiting of access to a recipient's records to personnel having direct involvement with the recipient subject to federal, state and DHH regulations. The recipient/guardian must give permission for case managers to share information with other agencies.

Consumer Direction - A voluntary waiver recipient or his/her authorized (appointed) representative has the right to choose services and/or supports which best fit their individual needs through the person-centered planning process. A fiscal agent must be contracted to provide certain functions on behalf of the consumer such as budget preparation and management.

Consumer - For the purposes of this policy, a consumer means the individual receiving waiver services and supports.

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

Corrective Action Plan - Written description of action a case management provider agency plans to take to correct deficiencies identified by the provider's Quality Improvement Planning Committee or by BCSS Regional staff.

Comprehensive Plan of Care (CPOC)- The CPOC is a person-centered planning process designed cooperatively by the case manager, the recipient and other persons invited by the recipient, who may include family members, a provider, appropriate professionals, and others who know the recipient best. The recipient's BCSS approved CPOC shall reflect only the services needed. The BCSS approved CPOC will contain all paid and unpaid natural support services that are necessary to assist the recipient in his/her residence and promote greater independence. Payment shall be made for only those approved services received by the recipient.

Crossover Medicare/Medicaid Claims - Claims received on a Medicaid-eligible recipient who has both Medicare and Medicaid coverage. (Medicare does not pay for case management services.)

Diagnosis and Evaluation (D&E) - A process conducted by an appropriate professional to determine the level of disability of the recipient and make recommendations for remediation.

De-certification - Removal from the waiver by BCSS subsequent to review by the Service/Peer Review Panel.

Department of Health and Hospitals (DHH) -The state agency responsible for administering the Medicaid Program and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services. In this manual the use of the word Department will mean DHH.

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

Department of Social Services (DSS) - The state agency responsible for administering social services including Family Independence Temporary Assistance Program (FITAP), Food Stamps, children's protective services, foster care and vocational rehabilitation services.

Developmental Disability (DD) -
Defined in La. R.S. 28:380 as amended in 1983 as a severe chronic disability of a person which is attributable to:

- Mental retardation, cerebral palsy, epilepsy; or autism OR,
- Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, or requires treatment or services similar to those required for these persons; AND,
- Which is manifested before the person reaches age 22; AND,
- Which is likely to continue indefinitely; AND,
- Which results in substantial functional limitations in three or more of the following areas of major life activity: Self-care, Understanding and use of language, Learning, Mobility, Self-direction, Capacity for independent living?

Direct Service Provider (DSP) - Medicaid enrolled agency that provides needed services including medical, social, educational and other support services to eligible recipients.

Direct Support - An individual who provides hands -on services and active supports to a recipients.

Discharge - Removal from the waiver for reasons established by BCSS.

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

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

Enrollment - The process of executing a contract with a potential provider for participation in the Medicaid program if the agency meets the necessary requirements. Also referred to as provider enrollment or certification.

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)

Fiscal Agent (FA) - An organization or entity that assists a recipient or the recipient's family to manage and distribute funds allocated for services.

Fiscal Intermediary (FI) -The entity that DHH contracts with to pay the Medicaid claims. Refer to MMIS.

Freedom of Choice (FOC) - The process that allows an individual to review all case management agencies and provider agencies and to select their case management agency and provider agency.

Fraud - The definition that governs between citizens and government agencies is found in La.R.S. 14:67 and La.R.S. 14:70.01. Legal action may also be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-30).

HIPAA - Health Insurance Portability and Accountability Act

Home and Community-Based Services (HOME AND COMMUNITY BASED SERVICES) - A collection of waiver services available in a community setting to enable recipients who qualify for institutional care to remain in their own home or community based setting. These are administered under a special Medicaid program and provided by BCSS.

ICF/MR - Intermediate Care Facility/Mentally Retarded

Individual Budget - An amount of dollars over which the recipient or his/her family (as appropriate) exercised decision-making authority concerning the selection of services, service providers, and the amount of services.

Informal Support - Another term for non-paid services provided by family, friends and community/social network.

Institutionalization - Placement of a recipient in any inpatient facility including a hospital, group home for the mentally retarded, nursing facility, or psychiatric hospital.

Intake - The screening process consisting of activities necessary to determine the need and eligibility for Medicaid provided services, including case management services.

Licensure[1] - A determination by the DHH/BCSS that a case management provider agency meets the state requirements to provide client care services, specifically, case management/service coordination services.

Licensure[2] -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.

Linkage - A core element of case management defined as implementation of the service plan and arranging of a continuum of formal/professional and informal services to be provided to the recipient.

LOC - Level of Care - The level of care for the NOW is an ICF/MR, which is Intermediate Care Facility for the Mentally Retarded.

LTC - Long Term Care.

MD - Medical Doctor

Medicaid/Medicaid Program - Medical assistance provided under the State Plan approved by the Center for Medicare and Medicaid Services (CMS) 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.

Medicaid - A federal-state financed entitlement program, which provides medical services primarily to low-income individuals under a State Plan approved under Title XIX of the Social Security Act.

New Opportunities Waiver (NOW) - Mental Retardation/Development Disability Waiver program providing 10 services not available to other Medicaid recipients in lieu of providing institutional care to individuals of any age meeting the federal definition for mental retardation or a developmental disability and who meet certain financial criteria.

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)

Monitoring - The ongoing oversight of the provision of home and community-based services and other services in order to determine that they are furnished according to the recipient's plan of care and effectively meet his/her needs, including health and welfare. It is also an element of case management, which refers to the follow-up mechanism to assure applicability of the service plan. BCSS Regional staff is responsible for performing on-site reviews of case management providers to determine compliance with Medicaid policies and procedures

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

Multi-disciplinary Evaluation (MDE) - The testing of an infant or toddler by a group of professionals including infant development specialists, speech therapists, physical therapists, occupational therapists, social workers, nurses, etc.

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/her well being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 14:403.2).

NOW - New Opportunities Waiver

OCDD - Office for Citizens with Developmental Disabilities (previously the Office of Mental Retardation/ Developmental Disabilities). The Office in DHH responsible for services to developmentally disabled citizens in Louisiana.

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

PA - Prior Authorization is the authorization for service delivery, based on the BCSS approved CPOC and sent to providers and must be obtained before any services can be provided.

Recipient/Participant - An individual who is eligible for Medicaid and waiver services and supports through the Bureau of Community Supports and 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, case manager, 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.

Person-Centered Planning - A process directed by the recipient or the recipient's family (when appropriate) that is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the recipient.

Person with Disabilities - Is a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for his own care or protection.

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

Plans of Correction - (POC) are developed by a provider in response to deficient practice citations. Required components of the POC include the following:

- What corrective actions will be accomplished for those waiver recipients found to have been affected by the deficient practice;

- How other individuals being provided services and support who have the potential to be affected by the deficient practice will be provided corrective care resulting from the Plan of Correction;

- The measures that will be put into place or the systemic changes that will be made to ensure that the deficient practice will not recur; and

- How the corrective measures will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place regarding the identified deficient practice.

Pre-cert Home Visit – The visit the Regional BCSS office makes to an individual's home prior to certifying them for NOW services.

Provider - An agency furnishing targeted or waiver case management services under a provider agreement with DHH. Also referred to as provider agency.

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

Provider Enrollment - Another term for enrollment.

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

QI - Quality Improvement.

Quality Management - The section of BCSS whose responsibilities include the constellation of activities undertaken to promote the provision of effective services and supports on behalf of recipients and to assure their health and welfare. Quality management activities ensure that program standards and requirements are met.

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

Recipient/Participant - Any individual who has been determined eligible for Medicaid. See definition on page 32-101.

Recipient/ Legal Guardian - The individual receiving services, or the responsible party, or a parent. All references to recipient include the parent or Legal guardian if the recipient has been interdicted or is a minor.

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

Request for Services Registry (RFSR) - The process by which an individual verifies their desire to participate in the NOW program.

Responsible Party - Any individual/group designated by a Medicaid-eligible to act as official agent in dealing with DHH and/or a provider. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

RN - Registered Nurse.

Secretary - The Secretary of the Department of Health and Hospitals.

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)

Self-Determination:

Principles of Self-Determination:

Freedom to live a meaningful life in the community
Authority over dollars needed for support
Support to organize resources in ways that are life enhancing and meaningful
Responsibility for the wise use of public dollars

Confirmation of the important leadership that self advocates must hold in a newly designed system.

Service Plan - The written agreement that specifies the long-range goals, short-term objectives, specific action steps or services, assignment of responsibility, and time frames for completion or review.

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.

SOE - Statement of Eligibility or Summary of Evidence

SPOE - Single Point of Entry.

SSA - Social Security Administration.

SSN - Social Security Number.

Third Party Liability (TPL) - Refers to the responsibility of another payer (Medicare, insurance, etc.) to pay benefits for services before Medicaid pays. Medicaid is generally the payer of last resort.

Title XIX - The section of the Social Security Act, which is applicable to Medicaid services.

Transition - Refers to the steps to support the passage of the recipient to existing formal or informal services to the extent appropriate or out of services completely.

UR - Utilization Review.

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

APPENDIX A-Now CPOC Forms

- Instruction for CPOC Forms
- CPOC Revision Request
- Sensitive Information Forms
- Consent for Authorized Representation
- Transition "Walk Over" Forms
- Now Transitional Expense and Planning
- Replacement PA Request Environmental
- Documentation For Authorization of Shared Staff
- Accessibility Modification Job Completion Form
- People First Language

New Opportunities Waiver (NOW)

Instructions for the Comprehensive Plan of Care (CPOC) Form

REISSUED NOVEMBER 18, 2003

Louisiana Department of Health and Hospitals

Bureau of Community Supports and Services
New Opportunities Waiver (NOW)
Comprehensive Plan of Care Instructions

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CPOC GENERAL PURPOSE

The Comprehensive Plan of Care (CPOC) establishes direction for all persons involved in providing supports and services for the recipient being assessed for home and community-based waiver services, or for those already receiving services. The CPOC reflects information shared by the recipient requesting/receiving services, as well as by those who know him/her best. The primary goal of the CPOC process is to learn as much as possible directly from the recipient and those who support him/her. This personal perspective assists those who provide supports and services to identify the recipient's expectations, desired outcomes and guide service activities.

An individual support plan should be a statement of the recipient's vision for the future and the services designed to assist the recipient to move towards that future. The CPOC is a tool used to document specific information about individualized supports for each recipient. It also communicates priorities to all support personnel and provides a point of reference for reviewing progress and change.

The CPOC is developed through a flexible, **on-going collaborative** process involving the individual, family, friends or other support systems, the case manager and appropriate service providers. Plans are based on information from the recipient, his/her primary support network and other service personnel who know and interact with the recipient. It reflects discussion and decisions about services and supports during planning sessions. The plan provides a road map for the achievement of personal outcomes.

Learning about the recipient does not stop when the planning session is completed. Interacting with people as they experience new opportunities and situations provides new information that can be used to initiate, and/or enhance the effectiveness of supports and services (both formal and informal) that can be combined to enable people to live the lifestyle they want to live.

The information contained in this instruction manual identifies and explains how to complete various sections/components of the NOW CPOC. This manual is not to be considered a stand-alone document in the development of a recipient's plan of care, but rather used as a guide in the collection, planning, execution, evaluation and on-going documentation of valuable, key information. Significant movement toward the lifestyle a recipient prefers and is satisfied with can only happen through the development of a network of people (paid and unpaid) who are committed, willing and able to listen to the recipient's desired outcomes, and then build supports to achieve those outcomes.

Most importantly, keep in mind the purpose of the planning session. The planning session should create a shared understanding of the recipient's priorities and a sense of excitement and possibility for his/her future.

DEMOGRAPHIC INFORMATION

IMPORTANT NOTE: The individual's full name (last name first) should appear at the bottom of every page of the CPOC).

Purpose

This initial section of the CPOC contains basic identifying and descriptive information regarding the recipient.

Type:	Indicate the reason for completing the CPOC. If this is the first time CPOC is being completed on a recipient, check the box marked "INITIAL". Check the box marked "ANNUAL" for all subsequent CPOCs (i.e., submitted after the recipient's initial approved CPOC).
Waiver:	Identifies the New Opportunities Waiver (NOW) as the recipient's preferred choice of home and community-based waiver services.
Level of Care:	Identifies the "level of care" as identified on the 90L (Physician's Medical Authorization for Long Term Care placement).
Shared Support:	Indicate if the recipient is receiving shared support services.
Recipient's Name:	Indicate the recipient's full **legal** name, last name first.
Social Security Number:	Indicate the recipient's social security number.
Date of Birth (DOB):	Indicate the recipient's date of birth.
Medicaid Number:	Indicate the recipient's 13 digit **Medicaid** number. Do not use control card number (i.e., 7770000.....)
Medicare Number:	Indicate the recipient's **Medicare** Number.
Address:	List the recipient's physical address (place of residence), **including zip code**. If the recipient's mailing address is different from his/her physical address, note that information under "Mailing (if different)" section.
Parish:	Parish in which the recipient resides.

Day Phone Number(s)/ Night Phone Number(s): Phone number(s) where the recipient can be reached during daytime and nighttime hours.

Legal Guardian: List the name of the individual (if any) who has a written, legal right to act on the recipient's behalf. Attach a copy of the legal document indicating guardianship to the CPOC. Indicate if recipient listed is Legal Guardian or authorized representative by circling appropriate designation.

Authorized Representative: List the name of the individual (if any) who has written authorization from the recipient to act on his/her behalf. A BCSS "Consent For Authorized Representation" Form must be completed in the event the recipient has designated someone to act on his or her behalf (this form can be found in appendix A of this instruction manual).

Relationship: Indicate what relationship Legal Guardian or Authorized Representative has to the recipient (i.e., parent, brother, sister, aunt, uncle, friend, etc.).

Legal Status: Indicate the recipient's "legal status" as far as his/her "legal" ability to make his/her own decisions regarding medical, financial and other areas of care. For a recipient whose legal status is identified as "Interdicted", "Power of Attorney", or "Minor", please attach a copy of the legal document denoting that status. Legal document must be submitted with initial CPOC or upon change in legal status. Continuing tutorship should to be noted (attach legal documentation).

Address: Indicate the Legal Guardian/Authorized Representative's address (physical and/or mailing address) if different from the recipient's address.

Day Phone Number/ Night Phone Number: Indicate the phone number(s) (including area code) where the legal guardian or authorized representative can be reached during daytime and nighttime hours.

Case Management Agency: Indicate the name of the case management agency that will be working with the recipient/family. Use Agency's full name (no acronyms).

Case Management Agency Address:	Indicate the case management agency's physical and mailing address.
Provider Number:	Indicate the case management agency's Medicaid provider number.
Contact Person:	Indicate the assigned case manager's full name.
Telephone Number:	Indicate the case management agency's telephone number (including area code).
Sex:	Indicate the recipient's gender/sex.
Race:	Indicate the recipient's race.
Education:	Indicate if the recipient attends school or if she/he receives homebound services.
90L:	Indicate the date the physician signed the 90L and the date the case management agency received the 90L.
Primary Disability/ Diagnosis:	Indicate the recipient's primary diagnosis and the date of onset.
Secondary Disability/ Diagnosis:	Indicate the recipient's secondary diagnosis and date of onset.
Level of MR:	Indicate the recipient's level of mental retardation (MR) as identified on the recipient's psychological evaluation or 1508 school evaluation form.
Adaptive Functioning:	Indicate the recipient's level of adaptive functioning as identified on the recipient's psychological evaluation or 1508-school evaluation form.
Ambulation:	Indicate the recipient's ability to **walk**. **Independent:** Individual is able to walk independently without personal assistance, and/or the use of assistive devices. **With Personal Assistance**: Individual is able to walk with personal assistance such as assistance to stand before he/she begins walking, assistance to steady gait, and/or guided maneuvering once walking begins.

With Assistive Device(s): Individual is able to walk with the use of an assistive device(s) such as a walker, crutches, cane, etc.
Does not Ambulate: Unable to walk independently, with assistance, and/or with assistive devices.

Primary mode of Locomotion: Indicate the recipient's primary mode of locomotion (i.e., primary means of getting from one place to another).
Ambulation: Recipient is able to walk independently, and/or with personal assistance.
Wheelchair without Assistance: Recipient is able to self propel manual wheelchair, or is able to self maneuver motorized wheelchair.
Wheelchair with Assistance: Recipient requires assistance with propelling manual wheelchair, or with maneuvering motorized wheelchair.
Other: Any other primary means of locomotion not noted above.

SIL: Indicate if the recipient is receiving supervised independent living (SIL) services.

24 Hour Services: Indicate if the recipient is receiving 24 hours of paid supports through the home and community-based waiver program.

Mobile with Assistive Device: Indicate if the recipient is capable of moving about with an assistive device (i.e., wheelchair, walker, etc.).

Emergency Self-Evacuate: Indicate if the recipient is able to self-evacuate in the event of an emergency. **Attach a copy of the recipient's emergency evacuation/response plan to the CPOC.**

Emergency Response: Indicate the recipient's emergency response level as defined below by checking the appropriate box:

Level 1: The recipient requires **total assistance with life sustaining equipment** (i.e., equipment is required to sustain the recipient's life, generally equipment is powered by electricity, and/or electricity is required as a backup).

Level 2: The recipient requires **total assistance** to respond to an emergency situation.

Level 3: The recipient can **respond independently to an emergency but needs transportation** to complete this process.

Level 4: The recipient can **respond independently** (i.e., has available supports to meet all his/her needs in an emergency situation, including transportation).

Will residence change with Waiver participation?: Indicate if the recipient will be moving to another place of residence upon participation in a home and community-based waiver program. **If yes:** indicate proposed date and address, including house number/apartment number, street, city, state and zip code.

Is this a transition from a Developmental Center, Nursing Facility, Other?: Indicate if the recipient is moving from a developmental center, a nursing facility or other facility to a home and community-based setting.

Deposits Required: Indicate if the recipient, upon receipt of home and community-based waiver services, will require deposit fee(s) in order to establish his/her new place of residence.

Are there multiple Waiver recipients in the home?: Indicate if there are multiple recipients of any type of home and community-based waiver services residing in the recipient's home. **If "Yes"**, how many?

Are there multiple Individuals with Disabilities (non recipients) in the home?: Indicate if there are disabled individuals who reside in the home who do not receive waiver services. **If "Yes", how many?**

Are paid caregivers related to the recipient?: If yes, relationship and service provided: Indicate if any of the paid caregivers are related to the recipient.

Do paid caregivers live with the recipient?: Indicate if paid caregiver(s) live with the recipient. **If yes, indicate name and service(s) provided.**

Present Housing: Check the box for the type of housing the recipient currently resides in (i.e., own home, apartment, etc.) and then check the box indicating if the recipient is renting, buying, subsidized housing, etc.

Anticipated Housing: Indicate the type of housing the recipient will be living in if he/she anticipates a change of residence once waiver services are in place.

FOR BCSS USE ONLY: **BCSS staff will complete this section.**

SECTION I - EMERGENCY INFORMATION

Purpose

There are several possible situations that necessitate having current, easily accessible personal and medical information and workable evacuation plans in place. Medical emergencies, fire, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and other emergency situations should all be considered when planning for the safety and well being of recipients we support.

Not knowing what to do or whom to call in an emergency is unacceptable. Reduced response/escape time may mean the difference between life and death.

Pre-emergency assessment, and thoughtful planning and practice which considers the individual needs of recipients with physical, mental, and/or memory impairments foster independence and empowers individuals and those who support them to respond quickly and efficiently at the onset of an emergency.

Information noted in this section, among other uses, will provide a quick reference regarding a recipient's ability to evacuate in the event of an emergency. Circle of support contact information, doctor(s) name(s) and phone number(s), as well as other essential information is also included in this section.

INDIVIDUALIZED EMERGENCY EVACUATION/ RESPONSE PLAN ATTACHED: Individualized Emergency Evacuation/**Response Plan must be attached to the CPOC.**

INDIVIDUAL'S NAME, AGE, ADDRESS AND DIRECTION TO HOME: Indicate the recipient's full name, age, physical address, and directions to his/her home. Directions to the recipient's home should be clear, concise and if at all

possible, refer to a landmark as a starting point of reference.

PERSON RESPONSIBLE FOR EVACUATING OR BRINGING SUPPLIES TO THE RECIPIENT'S HOME:

The person(s) who will be responsible for assisting the recipient in the event of an emergency/evacuation should be clearly noted in this section **(AGENCY NAME IS NOT SUFFICIENT - LIST DESIGNATED PERSON/STAFF).**

FAMILY MEMBERS/OTHERS TO CONTACT IN CASE OF AN EMERGENCY (INCLUDING PROVIDERS):

A list of individuals who are to be contacted in the event of an emergency should be clearly noted in this section.

EMERGENCY EQUIPMENT IN THE HOME:

Indicate if the recipient has the following emergency equipment (in working order) in the home, and state location of equipment: 1) Fire Extinguisher, 2) Home Evacuation Plan, 3) First Aid Supplies, 4) Specialized Medical Equipment (For example, ventilator, suction machine, nebulizer, etc.), 5) Smoke Detector, 6) other emergency equipment (list what "other" equipment is).

> ***IMPORTANT NOTE:*** *The safety and well being of a recipient should always be considered of prime importance. Each individual situation should be thoroughly assessed to assure that circumstances specific to that individual are taken in to consideration when planning for the safety and well being of that recipient.* ***If emergency equipment, well thought out plans for evacuation and the recipient's understanding of how/when to evacuate are not found to be present, an Outcomes goal in Section V should reflect how this situation will be remedied.*** *A specific target date for initial review of the Outcomes goal in this section should be set as soon as possible, but no later than the first quarterly review.* ***Safety issues that pose an immediate threat should be dealt with immediately.***

The case manager is responsible for assuring that the necessary steps to correct the situation are taken and documented as such. The case manager should explore all paid and unpaid resources to assist an individual, and/or his/her circle of support obtain the necessary equipment/supplies to correct this situation. It is important to remember that the main focus in an emergency should always be on making sure the individual is out of harms way as soon as possible. For example, an individual we are support should not attempt to use a fire extinguisher to put out a fire – he/she should be assisted or taught how to quickly and safely exit an unsafe area/situation.

Special Considerations/Necessities (Detailed Information Required): assistive technology, ventilator dependent, medications, etc. (See Individual Emergency Evacuation /Response Plan): Person-specific considerations should be identified and addressed in the individual's attached emergency evacuation/response plan.

Recipient's Doctor(s): List the individual's primary physician (full name), his/her specialty (area of practice), and a phone number where he/she may be reached. Include the name(s), specialty and phone number(s) of other doctors the recipient may see for routine, and/or specialized care.

SECTION II - HEALTH PROFILE*

Be especially aware of any information in this section the individual may deem as "Sensitive Information" and follow appropriate guidelines (refer to **"Sensitive Information" form in Appendix A of this instruction manual).*

Purpose

An individual's health profile is a collection of health and medical information obtained from the recipient, individuals who know the recipient best, other sources such as an individual's physicians, other health care providers, medical and/or psychological records. Persons with disabilities that interfere with cognition or communication my not be able to either recognize or tell anyone about significant changes in health status. In these cases, individuals who know the recipient best can provide an invaluable source of information.

A thorough collection of information concerning an individuals health profile and current health status can be an invaluable tool in early identification and monitoring of potential health and welfare concerns when working with developmentally disabled populations, especially those individuals who may have a history of unstable health conditions.

Information documented in this section will guide the individual's support team in assuring that appropriate, adequate and person centered supports are addressed in the support planning process.

This section summarizes important aspects of the recipient's physical and mental health status, medication needs, adaptive functioning capabilities/needs, frequency and reason for doctor visits, preventive medical/dental check up schedules, and/or specialized medical follow up such as monitoring of medications, blood pressure, lab values, and other need

A. Health Status

1. **Physical:** This section describes the individual's functional and sensory abilities in the area of vision, hearing, physical mobility, use of arms/hands, need for assistive devices, and over all health status.

2. **Allergies to medication/food/airborne: ("What does it look like?):** Indicate the type and severity of allergy, whether or not individual requires medical intervention as a result of allergic reaction, need for special anti-allergy/emergency treatments, if under doctor's care for allergies, etc.

3. **Medical Diagnoses:** This section describes the individual's medical diagnosis as stated in the Physician's Medical Authorization for Long Term Care placement (90L) and other medical documentation. Medical concerns and significant medical history should be listed in this section. If an individual has a diagnosis of seizure, a seizure protocol must be attached.

4. **Doctor's Visits:** This section describes any routine doctor's visits, routine lab work, monitoring of chronic, and/or acute health conditions/concerns, as well as emergency doctor visits. Indicate frequency of follow up visits if needed.

5. **Psychiatric/Behavioral Concerns:** This section provides a description of the individual's psychiatric status, diagnoses and behavioral problems which may impact his/her health status and/or ability to function. Significant social, affective, cognitive, and/or environmental factors that may trigger an inappropriate response (For example, threat or injury to self and/or others, etc.) should be noted. Behavioral issues and concerns should be documented and successful interventions described accordingly. History regarding skills training in dealing with: suicidal or homicidal ideation, intent or attempts; history of elopement; aggression; and inappropriate sexual behavior should also be detailed in accompanying documentation.

6. **Behavioral Support Plan:** This section describes the extent of staff and other support system required specifically for behavioral intervention as outlined in an individual's behavioral support plan. The intensity and frequency of such interventions are also described in this section.

7. **Critical Incidents (For past 6 months – list # of times each incident occurred):**
    a. Critical Incidents (as defined by BCSS Critical Incident Policy
    b. Non-Critical Incidents (as defined by BCSS Critical Incident Policy)
    c. Hospital Admissions: Frequency and reason(s) for hospital admissions.
    d. Emergency Doctor Visits: Frequency and reason(s) for emergency room visits.

e. Psychiatric Hospital Admissions: Frequency and reason(s) for psychiatric hospital admissions.
f. Other: Frequency and reason(s)for the critical incidents. Example of "Other" would be law enforcement involvement, or other items not already listed.

8. **Additional Information Summary Box:** Additional information for items listed under Incident reports should be noted in this area.

B. List of Medications: (Including Over The Counter Medications): Prescribed and over the counter medications are should be listed in this area. Medication name, what it is prescribed/used for, dosage/frequency, how taken (oral, patch, liquid, etc.), name of prescribing physician and who will be administering (self, family member, CMA, etc.) should be listed in this area. Physician Delegation should be noted and attached to CPOC when required.

> ***Important Note:*** *Awareness and proper management of an individual's medications, especially those used to stabilize, keep a medical condition from worsening, and/or avoid hospitalization should be of prime importance when discussing an individual's use of medications. Medication use should also be discussed when looking at emergency preparedness issues.*

C. List of Treatments (For example Catheterizations, Tube Feeding, Dressing Changes, Suctioning, Oxygen, Therapy, Splints, Braces, etc.): A complete list of the individual's treatments/procedures, including purpose of treatment/procedure, dosage/frequency, how prescribed and administered, prescribing physician, and person(s) administering the treatment should be listed in this section. Physician Delegation should be noted and attached to CPOC when required.

SECTION III - ALL ABOUT ME!*

Be especially aware of any information in this section the individual may deem as "Sensitive Information" and follow appropriate guidelines (refer to **"Sensitive Information" form in Appendix A of this instruction manual).*

Purpose

The purpose of this section is to gather information to gain a better understanding of the life experiences of an individual and his or her family. The approach needs to be relaxed with questions that provide an opportunity for the individual and/or the people who know him/her best to share life stories. An understanding and appreciation of positive and negative events in a recipient's life will provide beneficial insight to the individual and circle of support work necessary to develop a person-centered comprehensive plan of care (CPOC) support plan.

Information should to be written in a manner that supports the values and philosophy of a person-centered approach. **People First language** (Refer to information on "People First Language" in Appendix A of this instruction manual) is critical throughout the comprehensive plan of care. Language has the power to shape ideas and change perspectives. The language we use in our reports and plans are important because of the cumulative effect it has on the attitudes of caregivers, family members and community supports. It is important to use language that honestly paints a complete picture of the recipient. Emphasize **the person rather than the disability**. Remember that most individuals with a disability want to be thought of as ordinary people. State an individual's need in the context of performance or describe what is needed for success. Written information needs to be accurate and not judgmental. Describe the recipient's personality traits, capabilities and interests and other qualities that make the recipient, who he or she is, emphasizing abilities, not perceived limitations.

Some people have difficulty letting us know what their preferences, priorities and perspectives are. Some people communicate with gestures and some do not verbally communicate. The information gathering process may require extra attention to non-verbal means of communication. When gathering information from and about these individuals, we need to spend time with them in different settings to develop rapport and to observe how they interact (or don't interact) in various surroundings. Gathering information from different people who know the individual best is very important in learning about persons who have difficulty with language and verbal expression due to physical and cognitive limitations. People who are most familiar with the recipientmay be able to assist the interviewer in understanding the person's own communication method and style. They may also offer suggestions and guidance to enhance interactions and thus a better understanding of that individual's wants and needs. When asking questions of those who know the recipient best, be sure to ask how they know what they are telling you is so. For example, "How do you know that Mary likes to spend time outdoors?", "What makes you think that John dislikes carrots?" It may be necessary to include plans

Ask probing and open-ended questions in a conversational manner to gather information. This will promote detailed and descriptive life stories about experiences. Repeat what has been said to ensure that the information you are recording is accurate.

A. Historical Information:

Sample Questions (to weave into your conversation):

1. When were you born? Do you have brothers or sisters? Are you the oldest or youngest?

2. Was your mother's pregnancy difficult? Were there any complications during your birth? If so, what?

3. When did your doctor diagnose your disability? How old were you? Did the doctor tell you the cause of your disability?

4. What was your early childhood like? When did you walk, talk? What else do you remember?

5. Did you have any serious illnesses, hospitalizations or surgeries?

6. Did you attend school? If so when and where? Did you like school? What kinds of things did you learn to do?

7. Were there any major events in your family's life? What events have made a big difference in your life? Are there situations that have caused you to need support outside of your family and friends? If so, could you describe?

8. Have you ever had a job? What did you do? What did you like about your job? Did you earn a paycheck? What types of things did you do with the money you earned?

9. What has led you to request supports at this time?

B. Current Living Situation:

Sample Questions (to weave into your conversation):

1. What is you relationship with your family? Are you close? How often do you see each other? Does your family understand your disability? When you need assistance, are you or your family able to find the help you need? Where do you look for assistance? How easy is it for you to access community resources?

2. Who do you spend time with when you are not with your family? Are the people who spend time with you important to you? Are they your friends? Do you have a best friend? What does friend mean? Of all the people you know, whom do you feel closest to?

3. Who do you know in your community? When you go places, do you know and talk to people?

4. Who do you live with? Do you or your family have plans to change your living situation in the future? If so, what would those changes be? Does anyone you live with worry about being able to support you? If so, why? Do you rent or own your home? Do you participate in any housing program to help with your rent? What do you like about your current living situation? What would you change? Does your house meet your physical needs? If not, why? Do you feel safe in your home and neighborhood? If not, why?

5. Do you work? If so, where and for how long? What do you like about your job? Do you earn a paycheck?

6. Do you worry about having enough money to buy the things you need? Do you have enough money to do the things you would like to do? If not, what are some things you would like to be able to do?

7. Do you attend school? If so, where? What do you like about school? What would you like to change?

C. Current Community Supports or Other Agency Supports

Sample Questions (to weave into your conversation):

1. Who supports you besides your family? What kinds of things do they do with you or for you that support or assist you? How much time do you spend with each other? Do they ever ask for your help? If so, what are the kinds of things you do to help? Are you happy with the support you receive? Why? Is there anything you would change?

2. Who do you know in your community?

3. What types of interactions do you have with people in your community? For example: church, bank, shopping, volunteer work, YMCA, or clubs/civic groups. Are you a member of a church, fitness center like the YMCA or any other groups or clubs? When you go to these places, whom do you talk to? Whom do you spend time with? Would you like to spend more time with anyone?

4. What formal support do you receive from your community? For example: food assistance, such as the Food Bank, food stamps; housing assistance though the Housing Authority (such as the Rental Assistance program or Section 8 Voucher); legal assistance, such as probation officer, legal aid lawyer or the Advocacy Center. What kind of support do you need to be successful with your formal community supports?

SECTION IV - THINGS YOU NEED TO KNOW TO SUPPORT ME

Purpose

The purpose of this section is to get to know the individual, his or her personality traits, interests, capabilities, preferences and support needs to gain a better understanding of how to support him or her. Information is to be obtained in a ***positive*** and ***respectful*** manner that allows you to paint a full picture of the individual. Through this approach, the circle of support will strive to build services and supports that are individualized and responsive to the individual's personal preferences, interests and choices. This section of the comprehensive plan of care will guide and direct how people, such as direct support professionals, teachers, provider agency staff, family members, and others can play significant roles in the individual's life and assist them in planning individualized support and service delivery.

A. My Gifts and Talents

In this section you will ask open-ended questions to find out who the individual is. You will ask questions to determine the things people like about the individual, the things he or she likes about him/herself and the things he or she is known for… gifts, talents and strengths. It is important to remember that some gifts, talents and strengths could be both positive and negative making it critical to keep the circle of support's focus constructive.

Sample Questions (to weave into your conversation)

1. What are some things that people like about you? What are things about you that are respected by others? Admired? Valued? Appreciated?
2. What things about that would cause others to view you as good at something or competent?

3. What are the things/characteristics about you that create acceptance?

4. What are the things you like best about yourself? What about you makes you happy?

B. I communicate best by:

In this section you will identify the capacity of the individual to receive and express information. This is especially useful with individuals who communicate in non-traditional ways. It is an invaluable source of information for new support staff and for anyone who plays a significant role in understanding how an individual communicates with different people and in different situations.

Sample Questions (to weave into your conversation)

1. How do you communicate? (For example: gestures, body movements, speech, sign language, communication devices, pictures, written words, behave a certain way).

2. When do you communicate most? What activities are occurring?

3. What do you communicate? (For example, clapping hands means upset or happy, pulling on someone's hand means, "Let's go!").

4. Who do you communicate with on a regular basis? Is there anyone that you are more comfortable in going to when you need to say something?

C. I understand best when:

In this section you will identify how an individual learns best and assess how they receive and act on information. This information will provide beneficial insight into the individual's preferred learning style and enhance effective instruction that is respectful of the individual's preferences.

Sample Questions (to weave into your conversation)

1. How do you like to learn new things? What works best for you? (For example, modeling; show and tell; hand-over-hand technique; picture; checklist; show how the individual performs task, etc.). When do you like to learn new things? Morning? Afternoon? Evening?

2. When it is time for you to do something, what is the best way to tell you? (For example, show and tell me what I need to do; follow a picture routine; tell me in one step at a time; ask me not tell me).

D. I need help with:

In this section you will identify areas of difficulty as well as when an individual wants support. This will provide support staff, family members, and others significant to the individual with invaluable information in understanding basic support needs as well as when an individual feels he or she needs to be supported. This will provide knowledge of any characteristics or behaviors that pose challenges to community acceptance, promote rejection, or place the individual at risk. It is important to foster a positive focus to obtain constructive information.

Sample Questions (to weave into your conversation):

1. What are the things that you need help with? (For example: cooking, buying things, understanding when someone is taking advantage of me, and making friends).

2. What are some "in the way" things that keep you from doing the things you want to do? (For example, anger, talking loud, acting in a way that makes community members uncomfortable, taking things that don't belong to me, hitting people).

3. What support will help you? (For example, reminders of respectful behavior, redirection, role-play).

E. When I am scared I need someone to:

In this section you will identify situations that cause the individual to be scared and how to best support him or her to feel safe. This will provide important information to those who support the individual and, in particular, new direct support staff.

Sample Questions (to weave into your conversation)

1. What scares you? (For example situations, places, weather conditions, unknown changes in routine, people, animals, noises).
2. How can someone help you feel safe and not scared? (For example, talk to me in a soothing voice, hold me close, take me somewhere else, explain to me what is happening).
3. What makes you frustrated, angry or mad? (For example, changes in routine, loud people, being told what to do).
4. How can someone help you when you are angry? (For example, time alone, time alone with frequent checks to make sure I don't hurt myself, talking, redirection).

F. When I am angry I need you to:

In this section you will identify situations that cause an individual to become angry and how best to support him or her to diffuse or limit adverse behavior. This information will assist those significant to the individual, particularly new support staff, in avoiding unnecessary circumstances that create frustration and anger as well as in recognizing warning signals that the individual is becoming agitated. Anger is another form of communication, this section will provide strategies and tools to diffuse and respectfully deal with the individual's anger.

G. Things that work:

In this section you will identify what works for the individual. This will include people, places, things and activities that create motivation, enjoyment, excitement, happiness and engagement. You may discover that you have learned some of the things that work in previous sections. This

information should be recorded again in this section to provide a comprehensive list of "what works". Information will provide insight to the individual's personality and help support staff and significant others really know the individual. This is a very powerful tool in the development of individualized supports.

Sample Questions (to weave into your conversation)

1. What are your favorite activities? What do you do during your free time?
2. Do you collect anything, like cards or pictures?
3. What things make you happy, make you laugh or smile?
4. What makes a good day? Is your routine important? Do you like doing lots of different things each day?
5. What kind of people do you like? Who is most important to you?
6. Do you have a pet? If so, what is its name?
7. Where are some places you like to go?
8. What are your favorite foods?

H. Things that don't work:

In this section you will identify what doesn't work for the individual. This will include people, places, things and situations that create frustration, anger, upset, worry, boredom or depression. You may discover that you have learned some of the things that don't work in previous sections. This information should be recorded again in this section to provide a comprehensive list of "what doesn't work". Information will provide insight to the individual's personality and help support staff and significant others really get to know the individual, such as understanding what to avoid or when impossible, what support will be needed. This is a very powerful tool in the development of individualized supports.

Sample Questions (to weave into your conversation)

1. What are some things that make you scared, cry, sad or angry?
2. What situations or conditions need to be avoided? (For example, loud places, big crowds, lots of new people, stairs).
3. What situations cause you to be upset/angry? Bored? Scared? Depressed?

4. What foods don't work for you? (For example food allergies, texture, raw, cooked, hot or cold).

5. Are there people you should avoid? Who? Why?

6. What other things or situations don't work, cause problems or difficulty for you?

I. Other Things I would like you to know about me:

In this section you will help the individual identify what he or she believes are the most important things to know about him or her so that people can provide support effectively. You will use the information gathered in previous sections to summarize what is most critical which will especially help new support staff or substitute staff get to know and understand the individual.

Sample Questions (to weave into your conversation)

1. What do you think are the most important things for someone to know about you? (For example, routine, being prepared for changes, avoiding loud noises, favorite food, favorite thing to do).

2. What are the things that are most critical to your well being? (For example, situations to avoid, food allergies).

3. What are some "in the way" things that people need to know most about you? (For example, odd or unusual behaviors that are negative or have caused a bad reputation).

SECTION V - PERSONAL OUTCOMES

Purpose

Personal outcomes are what people expect from the services and supports they receive. Personal outcomes refer to the major expectations that people have in their lives. **The meaning for each of the Personal Outcome Measures is defined by the recipient**. Using the outcome measures in the planning process requires that we discover how the recipient defines the outcomes for him/herself (See Personal Outcomes Worksheet in NOW CPOC).

First Column – My Personal Outcomes

What the individual wants for him/her self in the future. Such "goals" can be formal statements of what a recipient wants to do or accomplish, or his/her informal expectations and hopes for the future.

Although an individual may have many hopes and desires for the future, the individual may choose to select only a few to actively pursue at any given time. Personal Outcomes may also be maintenance of something the recipient has already accomplished and wants to keep in his/her life. Not all of the 25 Personal Outcome Measures have to be included. The individual determines which ones are most important to work on at any given time. Outcomes may be addressed in the future.

Second Column – Support Strategy Needed

(What? Who? How?): "What" is needed for the individual to achieve his/her personal outcome. This section identifies the type of concrete action or support needed. This may reflect training needed, supports and/or skill acquisitions, or may be a statement regarding the individual's maintenance in the home and community with provided supports. "Who and How" the individual can be supported to achieve his/her personal outcome. This section identifies whether paid staff will be utilized or what natural supports (friends/family) are in place to support the strategy.

Third Column – How Often for Supports and Services

In this column, describe the frequency of service delivery the provider will use to meet the individual's needs and wants. For example, "Assist with bathing once daily. Hair washing three times weekly to be performed by family and paid staff." This section should be as specific as necessary to ensure adequacy of support.

Fourth Column – Review/Accomplishment Date

In this column, identify the frequency of when the CPOC will be reviewed. (Note: The CPOC must be reviewed at least quarterly and updated yearly.) The review will determine whether the individual's needs have been adequately met and whether the services continue to be wanted or needed in order to achieve, or move the recipient closer to his/her defined personal outcomes. Identify when the goal/outcome is accomplished. This section identifies the minimum requirements for review of the plan. It should be at least annually or sooner if the individual's situation significantly changes.

(Additional copies of this section can be made as needed).

SECTION VI - IDENTIFIED SERVICES, NEEDS, AND SUPPORTS

Purpose

The section will provide an overview of supports and services needed for the individual to promote independence. The chart will ensure that all supports and services have been assessed, discussed

and reviewed with the individual. The individual and his/her support system are provided with through information regarding home and community-based waiver services, other Medicaid funded programs, non-paid community supports and services so that they can make informed choices about services and supports they need and/or want in their lives.

In this section, identify the supports the individual has requested and/or is receiving. If an individual is receiving non-waiver support, write in the type of support under the sections marked, "Medicaid Funded Services" and/or "Non-Waiver Support".

The Case Manager is required to initial the bottom section of this page under "Note: Informed individual of all state plan services" indicating that they have indeed done so.

SECTION VII - TYPICAL WEEKLY SCHEDULE

Purpose

The intent of this schedule is to assist individuals and their families in assessing and planning for services and supports that will help them move closer to their desired personal outcomes. Utilization of this section and subsequent planning will help assure continuity of care and reduce redundant and/or unnecessary service delivery. Services should be provided in accordance with what is requested and needed by the individual, no more, no less. Simply list the source of service provision when applicable. In addition, for waiver support simply mark the time the individual typically receives supports by using the "Pw" coding. The service delivery schedule **is not** to be used for daily monitoring of service delivery or monitoring of the individual's daily activities.

This section is for planning purposes only. It is understood that this schedule is flexible and an individual's daily routine may change based on need or preference. The waiver supports that are initially requested will be based on this planning document.

Subsequent changes must to be requested by the individual, and/or his/her authorized representative, and processed through the case manager utilizing the appropriate Revision Request forms (see Revision Request Form in Appendix A of this instruction manual).

Typical Weekly Schedule

The top of this section lists the individual's desired/needed supports. For each hour indicate how the individual will typically spend his/her time using the codes listed below.

CODES:
F = Family
F = Friends
S = Self
Sc = School
C = Companion

Pw = Paid Waiver Support
P = Paid Support*

*Note: Paid Support is support provided by another funding source besides waiver funding (For example, Louisianan Rehab. Services (LRS), private pay funds, etc.).

When listing Paid Waiver Support (Pw), identify the waiver support (For example, PW – IFS, PW – Day Hab, etc.).

An example of a typical weekly schedule is:

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SAT	SUN
12pm	Pw – Individual Family Support (IFS)	Pw – Supported Employment (SE)	Friend (Fr)	Pw – SE	Self (S)	S	Fr

After completing the Typical Weekly Schedule, tally the hours by codes (For example Pw) and enter the number of hours next to the appropriate code in the box located on the bottom left-hand corner of the page. The total number of hours in a week is 168.

SECTION VIII - TYPICAL ALTERNATE SCHEDULE

(For Planning Purposes Only)

Purpose

The purpose of the Typical Alternate Schedule is to provide families flexibility in the utilization of units based on possible projected needs, (for example holidays, school closures, work schedule changes, etc.). Proper planning for the individual will allow for flexibility for families and the reduction of the need for revisions. This section is to assist with planning for holiday/vacation schedules, and to assure continuity of supports and services during those times when additional supports are requested. **It is understood that the schedule remains flexible**. Planning for holiday/ vacation or other alternate schedule time will ensure the individual will have access to the needed supports in a timely, consistent manner. **This page is simply designed to provide a visual overview of service delivery during holiday/vacation, or other alternate schedule time.**

Subsequent changes must be requested and processed through the case manager utilizing the appropriate Revision Request forms (See Appendix A of this Instruction Manual).

Typical Alternate Schedule Calendar

The Typical Alternate Schedule calendar contains the twelve (12) months of the year followed by the year: "20_____" (the appropriate year will need to be filled in). This calendar should begin and end with the months for that particular CPOC year. The dates when alternate services have been requested by the individual, and/or his/her authorized representative/guardian should be marked (this can be done by marking an "X" for appropriate date(s), by shading dates, or other means of marking dates. **Important Note:** Prior planning and consideration of all possible dates an individual may need alternate services at the CPOC planning meeting will provide families flexibility in the utilization of service units based on possible projected needs, and will minimize the need for revisions during the CPOC year.

For Example:

January 2004

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February 2004

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

March 2004

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS: Jan. 1 to 3, 2004 – School Winter Break, 1/19/04 – Martin Luther King, Jr. Holiday, 2/23 – 25, 2004 – Mardi Gras Holidays, 3/12/04 – Early dismissal – ½ day at school.

SECTION IX: - CPOC REQUESTED WAIVER SERVICES (BUDGET SHEET)

Section IX(A) - Typical Weekly Schedule & Section IX(B) - Typical Alternate Schedule

Purpose

The purpose of this section is to document all services an individual and/or his authorized representative/guardian have requested in accordance with information gathered and documented during the CPOC planning process. In addition, this section identifies whom the individual and/or his authorized representative/guardian have chosen to provide the specified service(s), the frequency, amount (units of service) and duration of each requested service for that particular CPOC year.

The Budget Page is divided into two (2) Sections - IX (A) and (B).

Section IX (A): List the Typical (Routine) Weekly Schedule – Daily Service Totals of services an individual has requested for that CPOC year. This schedule is reflected on a weekly schedule.

Section IX (B): List the Typical Alternate (Holiday/Vacation/Other) Schedule – Total Additional Units of Service being requested Per each quarter of the CPOC year. This schedule is reflected on a quarterly basis.

Signatures of the individual and/or his or her authorized representative, the chosen provider and case manager appear on this page documenting review and approval of services as reflected on Budget Sheets as written during the CPOC planning meeting.

BCSS is responsible for assuring that all information on the Budget Sheets is accurate before signing the approval of the CPOC as written.

The CPOC is a **legal document** and must be treated as such. The CPOC Budget Sheets must be completed in blue or black ink. **ALL** corrections must be made by **marking through an error only once and initialing each correction as such.**

Complete Section IX (A) & (B) of the CPOC (Budget Sheets) as follows:

SECTION IX (A) – BUDGET SHEET:

SSN#: Indicate the individual's SSN#

TYPICAL WEEKLY SCHEDULE – DAILY SERVICE TOTALS

List the individual's requested services as described in **Section V** of the individual's CPOC: **Identified Services, Needs, and Supports, Section VII: Typical Weekly Schedule**, and **Section VIII: Typical Alternate Schedule.** It is very important that the Budget Sheet (Section IX (A) & (B) be accurately and thoroughly completed so that delivery of supports and services is not adversely affected or delayed. Failure to do so will affect data input into the Prior Authorization system, which will ultimately **affect billing and delay reimbursement.** Each section should be completed as follows:

PROVIDER NAME: List provider agency to provide NOW service (Full Name, no acronyms).

SERVICE PROCEDURE CODE(S): List the NOW procedure code(s) for each requested service(s) (See attached NOW PROCEDURE CODES AND SERVICE RATES chart).

SERVICE TYPE: List the type of NOW service provided (For example, IFS, Day Hab, etc.)

MONDAY – SUNDAY: List the units of service for each NOW Procedure Code you have listed, under the day of the week they have been requested for.

TOATAL WEEKLY # OF UNITS OF SERVICE: List the total weekly number of units of service for each NOW Procedure Code listed.

TYPICAL ALTERNATE SCHEDULE – TOTAL ADDITIONAL UNITS OF SERVICE PER QUARTER

PROVIDER NAME: List the name of the provider agency that has been chosen by the individual/authorized rep./guardian to provide the service (Full Name, no acronyms).

SERVICE PROCEDURE CODES: List the NOW procedure code(s) for each service listed (See attached NOW PROCEDURE CODES AND SERVICE RATES chart).

SERVICE TYPE: List the type of NOW service being requested (For example, IFS, Day Hab, etc.)

TOTAL # OF UNITS (+ or -): Add (+) or subtract (-) total # of units of service for each additional service requested. **For example:** An individual receives Day Hab 3 days a week, 5 hours a day (20 Units per day, 60 units per week). During your CPOC planning meeting you learned that Day will be closed during the Christmas holidays for the 3 days this individual would normally attend Day Hab. The individual is requesting an additional 5 hours a day (an additional 20 Units per day, 60 units per week) of Individual Family Support (IFS) services for the 3 days during the Christmas holidays the Day Hab will be closed. You would subtract (-) the 3, 5 hour days of Day Hab Service (20 Units per day, 60 units per week) of Day Hab services for the appropriate CPOC Quarter and add (+) an additional 5 hours a day (an additional 20 Units per day, 60 units per week) of IFS for the appropriate CPOC quarter.

DATE/PURPOSE: Provide the date(s) when a request for alternate services are being added or subtracted and make a brief note indicating the purpose for additional (+) or for units of services being subtracted (-) (For example, "Holidays", "Early School Dismissals", "Vacation", "Illness" etc.)

QUARTERS: There are five sections listed. The first is a partial quarter, then the first full quarter, 2nd full quarter, 3rd full quarter and 4th partial quarter. The year that quarter is in should be noted at the top of each quarter by the "Yr. ___" Blank. **Be especially sure to note what year you are referring to for those times when alternate services may be covered in two different years for the same month. For example, a CPOC with alternate services requested for all quarters with a began date of July 15, 2003 would also cover alternate services through July 15, 2004.**

TOTAL ALT. COST FOR ALL QUARTERS: List the total cost for each quarter in the CPOC year (This is the total sum of each CPOC Quarter)

TOTAL TYPICAL ANNUAL ALTERNATE SCHEDULE COST: List the total cost for all Alternate units of service listed (Add or subtract each of the cost listed in this column to give you a Total Alternate Schedule Cost)

PROVIDER NAME/ PROVIDER REP. SIGNATURE: Signature(s) of provider agency representative(s) must be obtained **upon completion of the CPOC Service Budget Sheets (Section IX).** Service Provider **signatures will indicate that the providers have reviewed the budget sheet and are in agreement with services as outlined,** and that they are able to provide the services as requested by the individual and/or family/authorized rep.

CASE MANAGER: The Case Manager signs indicating that he/she has reviewed all NOW services with the individual, and/or with his authorized representative/guardian, and agrees that services as outlined on the CPOC Budget Sheet are indeed what the individual is requesting for that CPOC year.

BCSS APPROVAL SIGNATURE/INITIALS: BCSS is responsible for assuring that all information on the Budget Sheets is accurate before signing the approval of the CPOC as written.

Date: Date BCSS signs indicating approval of budget sheet.

NAME: Recipient's Name (last name first)

SECTION IX (B) – BUDGET SHEET:

1. **PROVIDER NAME:** List provider agency to provide NOW service (Full Name, no acronyms).

2. **PROVIDER #:** List the provider number assigned to each agency for billing purposes.

3. **SERVICE TYPE:** List the type of NOW service provided (For example, IFS, Day Hab, etc.)

4. **PROCEDURE CODE(S):** List the NOW procedure code(s) for each requested service(s) (See attached NOW PROCEDURE CODES AND SERVICE RATES chart).

5. **TOTAL WEEKLY # OF UNITS OF SERVICE:** List the total weekly number of units of service for each NOW Procedure Code listed.

6. **COST/RATE PER UNIT:** List cost/rate per unit of service assigned to each NOW service.

7. **TOTAL TYPICAL WEEKLY COSTS:** Multiply the Total Weekly # of units of service (#5) times (x) the Cost/Rate per Unit (#6). This will equal (=) the Total Typical Weekly Costs (#7).

8. **# OF WEEKS IN CPOC YEAR (52 weeks in a year):** Count the number of weeks in the Walk Over period for that particular CPOC (You would count from the Walk Over Begin Date to the Walk Over End Date. If Walk Over is submitted timely, this will be approximately 26 weeks. If Walk Over is submitted late, CPOC Begin Date will be 30 days after the CPOC is received in BCSS office and you would count from that CPOC Begin Date to CPOC End Date (It is **critical** that you submit Walk Over **timely**).

9. **TOTAL TYPICAL ANNUAL COSTS:** Multiply the Total Typical Weekly Costs (# 7) times (x) the # of weeks in CPOC Year (#8). This will equal (=) the Total Typical Weekly Walk Over Costs.

10. **TOTAL TYPICAL SCHEDULE ANNUAL COST:** Add all costs listed in column #9 to give you Total Typical Schedule Annual Cost (#10).

11. TOTAL TYPICAL ALTERNATE SCHECULE ANNUAL COST: List Typical Total Alternate Annual Cost as listed at bottom of Typical Alternate Schedule in Section (A) of CPOC Budget Sheet.

12. TOTAL COMBINED TYPICAL & ALT. SCHEDULE ANNUAL COST: Add Total Typical Schedule Annual Cost (#10) To Total Typical Alternate Schedule Annual Cost (#11) to give you Total Typical & Alt. Schedule Annual Cost (#12).

13. PROVIDER NAME/ PROVIDER REP. SIGNATURE: List the name of the Provider (full name), followed by the Provider Rep. Signature (Only primary service providers need to sign this page, unless otherwise indicated). **This signature will indicate that the provider has reviewed the budget sheet and agrees to provide the services as stated on the budget sheet.**

14. CASE MANAGER: The Case Manager signs on this line indicating that he/she has reviewed all NOW services with the individual, and/or with his authorized representative/guardian, and agrees that services as outlined on the CPOC Budget Sheet are indeed what the individual is requesting for that CPOC year.

15. BCSS APPROVAL SIGNATURE/ INITIALS: BCSS is responsible for assuring that all information on the Budget Sheets is accurate before signing the approval of the CPOC as written.

16. Date: Date BCSS signs indicating approval of budget sheet.

17. NAME: Recipient's Name (last name first)

SECTION X - CPOC PARTICIPANTS:

Purpose

This section should contain the signatures of all those who participated in the CPOC planning meeting. The signature(s) identify the individual's Circle of Support, and their signatures indicate participation in the CPOC planning meeting.

The Case Manager's signature and the Case Manager Supervisor's signature (indicating they have reviewed the CPOC) are required.

The next section outlines the recipient's rights and responsibilities and indicates his/her understanding of waiver supports as presented in the CPOC. The recipient (or authorized representative) initials and signs if he/she is in agreement with statements. A witness signature is **ALWAYS** required.

CARE PLAN ACTION (FOR BCSS STAFF USE ONLY)

BCSS Staff will complete this section.

PERSONAL OUTCOMES WORKSHEETS

Purpose

Personal Outcome Measures:

Personal Outcomes were developed by The Council on Quality and Leadership, an international organization that has over 30 years experience supporting organizations in providing quality services to people. There are 25 Personal Outcomes divided into 7 areas: Identity, Autonomy, Affiliation, Attainment, Safeguards, Rights, and Health and Wellness. These outcomes are defined by the recipient and measure what people with disabilities SAY is important. In a personal outcome focused system the **focus is on the recipient being served, service action is based on the person's criteria, programs are designed for the and expectations for performance are defined by the recipient.**

Persons with mental retardation, elderly and disabled individuals and their families and advocates are asserting their own definitions of how services should be provided and how service quality should be measured. Utilizing a personal outcomes approach assists case managers, direct service providers, family, and community support systems in focusing on the desires, goals, well-being, responsiveness, and growth of each individual, rather than focusing on compliance with the organizational process.

Focusing on outcomes and person-centered planning, supports the recipient as the decision-maker. The case manager is a partner in this process. Case managers are in a pivotal position to support people with disabilities in understanding and assuming greater responsibility in their planning meetings in order to help assure that the recipient's wishes are clearly reflected in the written comprehensive plan of care. Case Managers facilitate, oversee and monitor the service/support plan among those who accept responsibility for implementing the plan. Flexible work schedules

will be required in supporting the people that you support. With the active support of Case Managers and others, the lives of Louisiana's citizens with disabilities will be greatly enhanced.

The Bureau of Community Supports and Services (BCSS) promotes the use of People First language (see people First Language reference in Appendix A of this instruction manual).

A. MY PERSONAL OUTCOMES WORKSHEET:

The facilitating the information gathering process needs to have a basic knowledge of the Council's Personal Outcome Measure in order to conduct a personal outcome interview in a conversational manner. Critical knowledge includes the key ideas for each of the outcome measures. An understanding of the key ideas for each outcome assists the recipient asking the question to learn about the recipient's definition and status for each outcome. Each case management agency is responsible for assuring that case managers are familiar with The Council's Personal Outcome Measures. Case managers should be provided with the Personal Outcome Measures Manual and Workbook to assist them in gathering information. A staff person who has been formally trained in Personal Outcomes can be a vital resource to an employee, especially during the employee's orientation period. Along with providing new case managers with reference materials on Personal Outcomes, case management agencies are responsible for assuring that all case managers are formally trained in the Personal Outcome Measures process as training opportunities are made available by the BCSS. Case managers should be aware that the **information gathering process is an ongoing one** and every opportunity should be taken to learn more about the recipient they are supporting to assure that quality, meaningful supports and services are in place. Support staff should continue to gather information from the recipient and those who know him/her best so that adjustments/changes, as wanted and needed by that recipient, can enhance the effectiveness of supports and services.

During an initial interaction, the goal is to gather as much information about personal outcomes as possible directly from the recipient. This provides a foundation of understanding about the recipient and his or her sense of priorities. Follow-up interaction and interviews with the others provide opportunities to gather additional information.

Some people have difficulty letting us know what their preferences, priorities and perspectives are. Some people communicate with gestures and some do not verbally communicate. The information gathering process may require extra attention to non-verbal means of communication. When gathering information from and about these individuals, we need to spend time with them in different settings to develop rapport and to observe how they interact (or don't interact) in various surroundings. Gathering information from different people who know the recipient best is very important in learning about persons who have difficulty with language and verbal expression due to physical and cognitive limitations. People who are most familiar with the recipient may be able to assist the interviewer in understanding the recipient's own communication method and style. They may also offer suggestions and guidance to enhance interactions and thus a better understanding of that recipient's wants and needs. When asking questions of those who know the best, be sure to ask how they know what they are telling you is so. Two examples

are: "How do you know that Mary likes to spend time outdoors?"; and "What makes you think that John dislikes carrots?" It may be necessary to include plans for ways to discover and learn more about that individual so that we can provide him/her with truly meaningful supports and services.

"My Personal Outcomes Worksheet" contains The Council's twenty-five (25) Personal Outcomes and is used as **an information-gathering tool** to learn the recipient's wants and needs from his/her or family's perspective.

Current Life Situation describes what is/is not happening in this recipient's life for each of the outcomes; Current Support Situation - Natural and Paid, describes what's going on/not going on that supports the recipient's desired outcomes; Current Level of Satisfaction rates the recipient's level of satisfaction in the different Personal Outcomes domains on a scale of 1 to 5 – "Not at all satisfied, Not very satisfied, Somewhat satisfied, Satisfied, and Very satisfied".

The process of matching the recipient's current situation with what he/she wants captures the essence of outcome measurement. For example, if the recipient has friends and is satisfied with the friendships he or she has formed, the current situation may meet the recipient's definition of the outcome. If the recipient states that he or she neither has nor wants friends, and additional information reflects that this is a personal decision made with full access to experience and support for making friends, there may be no discrepancies between the current circumstances and the outcome desired. This can be contrasted with the recipient who does not have friends, but does not have the skill, access, experience, or opportunity to make friends. Without friends and access to opportunity and support for making the decision about whether or not to have friends, the current situation cannot match the desired outcome.

Now think of the recipient who is the focus of planning. Compare the outcome as defined by his/her current experience. Do they match? If not, how close is the recipient to achieving that outcome? When the recipient's definition of the outcome and the current situation match, there is typically one or more processes is in place that supports that outcome. There will be some instances where people achieve outcomes even when there are no identifiable organizational supports in place.

When an outcome is present but no process can be identified, this may indicate the presence of an informal support network. It may also mean that the recipient no longer needs significant supports or services. The review of the support process is important to ensure that the presence of the outcome is not just a chance happening. Support processes, even if informal, are important to ensure that outcomes continue to be present for the recipient.

If the recipient has not achieved an outcome, supports should help him/her move toward that outcome. It is possible for a recipient to have an outcome that is not achieved even though there is a support process in place. The **outcomes** are the results we expect from the provision of supports and services. As **strategies** are developed to support what

the recipient defines as his/her personal outcomes (what they want/need as a result of services and supports), ask these questions:

Why are we providing this service?
To what end is this support directed?

This worksheet is to be completed during the **initial CPOC planning process,** as part of the Personal Outcomes base line information gathering process, at the very least **during the 6 month review period** to measure progress/movement toward the recipient's desired lifestyle, and again at the **CPOC annual renewal period** as a guide for adjustment/changes in the CPOC service support strategies.

B. TOP/MOST IMPORTANT PERSONAL OUTCOMES/GOALS

Each recipient has some outcomes that are more important than others. The recipient may identify these clearly, either verbally or through some form of communication. For some people, it may be necessary to determine priorities by gauging the impact this outcome may have on their lives. For example, a recipient who does not have the kind of job they want may have high priorities about work issues.

Utilize the information learned from the "My Personal Outcomes Worksheet", as well as other information gleaned during the CPOC information gathering and planning process to complete the **Top/Most Important Personal Outcomes/Goals Worksheet**. Take time to identify barriers and opportunities. Barriers are the roadblocks to the recipient achieving his/her outcome. Understanding barriers and opportunities in the recipient's life or in the service system is critical to planning new strategies for support. Frequently people stop supporting the recipient in working towards his/her outcome when the barriers are difficult. It is important to keep an open mind and to discuss and share ideas and opportunities (chances, openings, possibilities) that may lead to a successful outcome for that recipient.

Goals should be written as outcome statements and can actually be the outcome identified by the recipient. Following are examples of how this can be accomplished:

During the CPOC planning process, Pam identified that she wanted more control over her finances. To her, this meant having a checking account and an ATM card. She also wanted to pay her own bills. The team identified some effective strategies to help Pam, which included having a $100 balance initially. Her sister agreed to help her balance her checkbook each month. A staff person agreed to assist her in learning how to write a check. Pam agreed to only write checks when staff or her sister were with her while she was learning how to handle her money.

The goals were written as follows:

Goal (outcome): Pam will control her finances.
Objective: Pam will open a checking account with a $100 balance by September 1, 2003.

Objective: Pam will complete a course on budgeting by November 1, 2003.

Objective: Pam will pay her telephone bill by check each month for three consecutive months by February 2004.

In this example the support team used Pam's definition of the outcome to develop objectives. The objectives bring her closer to the outcome as she defines it. Note that the team did not abandon Pam by giving her total access to her money with no supports. They began sharing control with her as she learned how to assume more responsibility.

Goals are either personal goals chosen by the recipient or goals which lead to an outcome for him/her. Objectives are typically defined as time-limited, specific, measurable statements related to the person's goals. **Strategies** are developed for meeting the goals and objectives. It is important to continually evaluate whether the goals, objectives and strategies are leading to achievement of the recipient's outcomes. If they are not, ask "why" this is a necessary objective or strategy. Keep asking "why" until people identify the outcome that is expected for the service or support.

Action is important, but written documentation and what we do with it is equally as important. Do we use it to change our actions to bring the recipient closer to his/her outcomes?

This worksheet is to be completed during the **initial CPOC planning process**, at the **annual CPOC renewal period** and as a result of **significant changes in the recipient's current life condition** that may warrant a reassessment of the recipient's outcome priorities.

Remember that the Personal Outcomes Worksheets are to be utilized as **working documents** that will change over time as the recipient's life changes. It is critical that the information gathering and planning process be continuous, based on how that recipient defines his/her Personal Outcomes.

Important Note: Personal and Family Outcomes for families with young children focus on the items and issues that matter most to families raising a child with a disability. The "Top/Most Important Personal Outcomes/Goals" Worksheet should be utilized to assist **families** of young children to determine their child's Top/Most Important Personal Outcomes/Goals as applicable according to the age and particular situation of the child.

A WORD ABOUT CONFIDENTIALITY

ALL Bureau of Community Supports and Services staff (whether directly employed by or holding honorary contracts with the BCSS) are expected to be familiar and compliant with rules and procedures governing Confidentiality and Data Protection policies and procedures as outlined in

Policy Number 7008-79, *Rules and Disclosures of Medical Information* of the Department of Health and Hospitals (See Appendix A).

BCSS places great emphasis on the need to protect, to the fullest extent possible, the privacy of recipients, while permitting the disclosure of medical information as is required to fulfill the administrative responsibilities of the Bureau. This applies to manual and computerized records and conversations about recipients currently receiving, or seeking services administered by BCSS. Everyone working for the BCSS is under a legal duty to keep confidential information, held in whatever form, confidential.

Confidential information, includes obvious material such as medical records, as well as ''non-health'' information (For example a recipient's name, address, telephone number(s), social security number, date of birth, details of his or her financial or domestic circumstances, etc.) provided by a recipient of services, and/or by an applicant for services, as well as information provided by another agency, or by a relative or other person(s).

Guiding Principles

The following *BCSS Guiding Principles* governing Confidentiality should also be followed:

- Principle 1 - **Justify the purpose(s).** Every proposed use or transfer of a recipient's identifying, and/or medical information within or from an organization should be clearly defined and scrutinized.
- Principle 2 - **Verify the identity of the entity or status of person seeking disclosure.** Before any disclosure of an recipient's identifying, and/or medical information is made, reasonable means to verify the entity and/or status of the recipient to whom disclosure is to be made should be utilized.
- Principle 3 - **Access to a recipient's identifying, and/or medical information should be on a strict need to know basis.** Only those persons who need access to a recipient's identifying, and/or medical information, and who meet the criteria set forth in DHH Policy Number 7008-79 governing *Rules on Disclosures of Medical Information* (See Appendix A) should have access to it, and they should only have access to the information items that are reasonably necessary to fulfill the intent of the disclosure. **This includes all requests for confidential information from sister agencies that must be accompanied by a written request listing the information needed, and the reason(s) for the request. Only information that reasonably fulfills the intent of the disclosure will be provided.**
- Principle 4 - **Everyone should be aware of his/her responsibilities.** Action should be taken to ensure that those handling confidential information are aware of their responsibilities to respect confidentiality.
- Principle 5 - **Understand and comply with lawful rules and procedures governing confidentiality.** Every use of a recipient's identifying information, and/or medical information must be lawful. Failure to maintain information in a confidential manner can result in disciplinary proceedings being taken against a staff member.

Computerized Transmission of Confidential Data

The Department of Health and Hospitals and the BCSS have clear guidelines for computer use, which help protect unauthorized access to, and the integrity of data contained on BCSS computers. In brief: computers are used only for DHH/BCSS business, are password protected, virus checked and measures are taken to prevent access via e-mail or the Internet.

Staff should follow the precautions listed below to assure unauthorized access and the integrity of confidential data contained on BCSS/contracted agency computers:

- Computers should only be utilized for DHH/BCSS business.
- Individual passwords should be utilized and protected in compliance with BCSS guidelines.
- When computerized transmission of an Recipient's identifying information is considered to be essential, each item of information should be justified with the aim of reducing identifiability.
- BCSS staff should log-off of their computers at the end of each business day to protect data files from unauthorized access.
- Computer screens containing any confidential information should be protected from possible viewing by unauthorized staff, and/or others, and should never be left unattended.
- Rules governing access to BCSS offices containing confidential records/information (be it hard copy or computerized data) should be strictly followed to prevent access to confidential materials by unauthorized personal, and/or others.

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY SUPPORTS & SERVICES
NEW OPPORTUNITIES WAIVER (NOW)
COMPREHENSIVE PLAN OF CARE
CONFIDENTIAL

TYPE: ☐ INITIAL ☐ ANNUAL WAIVER: ■ NOW LEVEL OF CARE: ■ ICFMR ☐ SHARED SUPPORT

INDIVIDUAL'S NAME		LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE	
SOCIAL SECURITY NUMBER	DOB / /	RELATIONSHIP	
MEDICAID #	MEDICARE #	LEGAL STATUS: ☐ MINOR ☐ INTERDICTED ☐ POWER OF ATTORNEY ☐ COMPETENT MAJOR ☐ OTHER _____	
ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)	ADDRESS (PHYSICAL)	MAILING (IF DIFFERENT)
CITY/STATE/ZIP CODE	PARISH	CITY/STATE/ZIP CODE	PARISH
DAY PHONE	NIGHT PHONE	DAY PHONE	NIGHT PHONE
CASE MANAGEMENT AGENCY (NO ABBREVIATIONS)		PROVIDER NUMBER	
CASE MANAGEMENT AGENCY ADDRESS		CONTACT PERSON (CASE MANAGER)	
CITY/STATE/ZIP CODE		TELEPHONE NUMBER	

SEX: ☐ MALE ☐ FEMALE **ETHNICITY:** ☐ AFRICAN-AMERICAN ☐ CAUCASIAN ☐ HISPANIC ☐ ASIAN ☐ OTHER

EDUCATION: ☐ ATTENDS SCHOOL ☐ HOMEBOUND ☐ N/A **90L:** PHYSICIAN DATE: _____ CM REC'D: _____

\RY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /

SECONDARY DISABILITY/DIAGNOSIS: _____ **DATE OF ONSET:** / /

MR: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND ☐ OTHER _____

ADAPTIVE FUNCTIONING: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ PROFOUND **AMBULATION:** ☐ YES ☐ NO ☐ OTHER

SIL: ☐ YES ☐ NO **24-HOUR SERVICE:** ☐ YES ☐ NO **MOBILE WITH ASSISTIVE DEVICES:** ☐ YES ☐ NO

EMERGENCY SELF-EVACUATE: ☐ YES ☐ NO **Attach Individualized emergency evaluation/Response plan**

EMERGENCY RESPONSE: ☐ **LEVEL 1** TOTAL 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, WHEN & PROPOSED ADDRESS?

IS THIS A TRANSITION FROM A DEVELOPMENTAL CENTER OR NURSING FACILITY? ☐ YES ☐ NO DEPOSIT REQUIRED? ☐ YES ☐ NO

ARE THERE MULTIPLE WAIVER RECIPIENTS IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____

ARE THERE MULTIPLE INDIVIDUALS WITH DISABILITIES (NON-RECIPIENT) IN THE HOME? ☐ YES ☐ NO IF SO, HOW MANY? _____

ARE PAID CARE GIVERS RELATED TO INDIVIDUAL? ☐ YES ☐ NO IF YES, RELATIONSHIP & SERVICE PROVIDED

DO PAID CARE GIVERS LIVE WITH RECIPIENT? ☐ YES ☐ NO IF YES, NAME & SERVICE(S)

DOES INDIVIDUAL RECEIVE HOME HEALTH SERVICE ? ☐ NO ☐ YES IF YES, ATTACH A HOME HEALTH PLAN.

Present Housing
☐ Own Home (Alone)
☐ Own Home (With Partner)
☐ Own Home (With Others)
☐ Other's Home

☐ ICF/MR ☐ NURSING FACILITY

RENT HOME:
☐ WITH SUBSIDY
☐ WITHOUT SUBSIDY

RENT APARTMENT:
☐ WITH SUBSIDY
☐ WITHOUT SUBSIDY

ANTICIPATED HOUSING:

BCSS USE ONLY: HIGH RISK RECIPIENT? ☐ YES ☐ NO (IF YES, BCSS WILL ADD TO HIGH RISK TRACKING)

CPOC BEGIN DATE:		**CPOC END DATE:**	

Section I: Emergency Information **Confidential**

Attach Individualized Emergency Evacuation/Response Plan

INDIVIDUAL'S NAME: _____ AGE: _____

ADDRESS: _____

DIRECTIONS TO MY HOME: _____

_____

PERSON RESPONSIBLE FOR EVACUATING/BRINGING SUPPLIES TO INDIVIDUAL'S HOME:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

FAMILY MEMBERS/OTHER TO CONTACT IN CASE OF EMERGENCY (INCLUDING PROVIDERS):

1. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

2. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____

3. NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

ADDRESS _____

EMERGENCY EQUIPMENT IN HOME:

☐ FIRE EXTINGUISHER: LOCATION _____

☐ HOME EVACUATION PLAN: LOCATION: _____

☐ SMOKE DETECTOR(S): LOCATION: _____

☐ FIRST AID SUPPLIES: LOCATION _____

☐ SPECIALIZED MEDICAL EQUIPMENT: (E.G., VENTILATOR, SUCTION MACHINE, ETC.) LOCATION _____

☐ OTHER _____

SPECIAL CONSIDERATIONS/NECESSITIES (DETAILED INFORMATION REQUIRED): UTILIZES ASSISTIVE TECHNOLOGY, DEPENDENT ON VENTILATOR, MEDICATIONS, ETC. (SEE INDIVIDUAL EMERGENCY EVACUATION/RESPONSE PLAN)

_____

DOCTOR'S NAME: _____ PRIMARY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

DOCTOR'S NAME: _____ SPECIALTY: _____ PHONE: _____

NAME: _____

SECTION II: Health Profile **Confidential**

A Health Status

1. **PHYSICAL (e.g., GENERAL HEALTH, MOBILITY, ASSISTIVE DEVICES):**

2. **ALLERGIES (e.g., MEDICATION, FOOD, ENVIRONMENTAL):**

   DESCRIBE WHAT HAPPENS WHEN THERE IS AN ALLERGIC REACTION

3. **MEDICAL DIAGNOSES/SIGNIFICANT MEDICAL HISTORY/CONCERNS:**

4. **DOCTOR VISITS (PAST YEAR AND SCHEDULED VISITS):**

5. **PSYCHIATRIC/BEHAVIOR CONCERNS:**

6. **BEHAVIOR SUPPORT PLAN ATTACHED (IF NEEDED):** ☐ YES ☐ NO

7. **INCIDENT REPORTS (FOR PAST 6 MONTHS):**

   A. CRITICAL INCIDENTS
      1. UNPLANNED HOSPITAL #
      2. ER VISITS #
      3. PSYCHIATRIC ADMITS #
      4. ABUSE/NEGLECT #
      5. OTHER #
   B. NON-CRITICAL INCIDENTS #
   C. HOSPITAL ADMISSIONS #
   D. EMERGENCY DOCTOR VISITS #
   E. PSYCHIATRIC HOSPITAL ADMISSIONS #

ADDITIONAL INFORMATION/SUMMARY:

NAME: _____

B. LIST MEDICATIONS: (INCLUDING OVER THE COUNTER MEDICATIONS) **Confidential**

MEDICATIONS	WHAT IS IT FOR?	DOSAGE/FREQUENCY	HOW IS IT TAKEN?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	
6.				☐	
7.				☐	
8.				☐	
9.				☐	
10.				☐	

C. LIST OF TREATMENTS (e.g. CATHERIZATIONS, TUBE FEEDING, DRESSING CHANGES, SUCTIONING, OXYGEN, SPLINTS, BRACES, ETC.)

TREATMENTS	WHAT IS IT FOR?	FREQUENCY	HOW IS IT PERFORMED?	PRESCRIBING PHYSICIAN *(CHECK BOX IF PHYSICIAN DELEGATION IS NEEDED)	To Be Given by: (SELF, FAMILY, STAFF, CMA, CNA, ETC.)
1.				☐	
2.				☐	
3.				☐	
4.				☐	
5.				☐	

NAME: _____

Section III. All About Me — Confidential

Information included in this section is relevant to my life today and is my way of sharing social/family history with you. I pe that this information will be helpful in assisting you to help me achieve my personal outcomes. My personal tcomes worksheet (see attached Personal Outcomes Worksheets) will assist you in helping me tell you about myself. If I need assistance telling my story, please ask those who know me best.

A. HISTORICAL INFORMATION: Information in this section includes historical issues, for example, nature and cause of person's disability, person's age at onset of disability (if not known, please indicate by writing "unknown" in this section), education, work history; recurring situations that impact support needs; summary of events leading to request for support at this time.

B. CURRENT LIVING SITUATION: Information in this section includes family's involvement and understanding of individual's strengths, skills and abilities, current issues/situations that may present barriers to individual obtaining supports and services they desire, individual's/family/circle of support knowledge of disability and how individual wants to be supported; economic issues, including current employment; connections to community and natural supports, relationships/friends/family/other, where and with whom individual lives, rural/urban area, accessibility to resources, own home/rents/lives with relative/extended family/alone, does physical home environment meet accessibility/safety needs, ealth and age of family care-givers (if supported by family), feelings of safety and continuity of supports/care, etc.

C. CURRENT COMMUNITY SUPPORTS OR OTHER AGENCY INVOLVEMENT: Information in this section includes significant life events, including family issues, social/law enforcement issues, social services caseworker or Probation Officer involvement which may require interaction with legal/social agencies, current community supports and resources being utilized, etc.

NAME: _____

A. My gifts and talents:
B. I communicate best by (speaking, gesturing, communication board, sign language, behaving in certain ways, etc.):
C. I understand best when (shown and told how, shown, use hand-over hand techniques, etc.):
D. I need help with:
E. When I am scared I need someone to:
F. When I am angry I need you to:
G. Things that work/things I like (favorite things such as…food hobbies, past time):
H. Things that don't work/things I dislike:
I. Other things I'd like you to know about me:

NAME: _____

SECTION **PERSONAL OUTCOMES** **Confidential**

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specific** **Review Date Accomplished**

NAME: _____

BCSS-CPOC-NOW

ISSUED 04/28/03

SECTION: IDENTIFIED SERVICES, NEEDS, AND SUPPORTS — CONFIDENTIAL

IDENTIFIED SERVICES AND SUPPORTS THAT WILL HELP ME MAINTAIN AND/OR ACHIEVE MY PERSONAL OUTCOMES.

NOW	NOW	MEDICAID FUNDED SERVICES	NON-WAIVER SUPPORT
☐ Individual/Family Support (IFS) ☐ Day (D) ☐ Night (N) ☐ SHARED SUPPORTS ☐ IFS – D ☐ IFS – N ☐ SKILLED NURSING ☐ CID ☐ SUBSTITUTE FAMILY CARE ☐ CENTER-BASED RESPITE ☐ PROFESSIONAL CONSULTATION ☐ PROFESSIONAL SERVICES ☐ TRANSITION PROFESSIONAL SUPPORT ☐ SKILLED NURSING SERVICES ☐ ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS ☐ Specialized Medical Equipment and Supplies ☐ Personal Emergency Response SYSTEM (PERS) ☐ Community Integration Development (CID)	☐ **Supported Employment** ☐ Transportation – REG ☐ TRANSPORTATION – W/C ☐ EMPLOYMENT-RELATED TRAINING ☐ DAY HABILITATION ☐ DAY HAB/EMPLOYMENT-RELATED TRAINING SERVICES TRANSPORTATION ☐ TRANSPORTATION – REG ☐ TRANSPORTATION – W/C	☐ Dental ☐ Eye Glasses ☐ Home Health Extended ☐ Hospice ☐ Medical Transportation ☐ Mental Health ☐ Podiatry Services ☐ Substance Abuse ☐ Prescriptions/Medication ☐ Others	☐ OCDD ☐ LRS ☐ DSS
☐ Supported Independent Living (SIL)			
☐ One-Time Transitional Support			

(NOTE: INFORMED INDIVIDUAL OF ALL STATE PLAN SERVICES. CASE MANAGER INITIALS: _____)

NAME: _____

Section VII: Typical Weekly Schedule

Confidential

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
)0 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
0 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE	HOURS
F = FAMILY	
FR = FRIENDS	
S = SELF	
SC = SCHOOL	
W = WORK	
PW = PAID WAIVER	
P = PAID SUPPORT	
al	

COMMENTS:

* FOR ALL PW SERVICES IDENTIFY – EXAMPLE = PW-IFS

NAME: _____

BCSS-CPOC-NOW

ISSUED 04/28/03

Section VIII – Alternate Schedule Confidential

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

January 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

March 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS: _____

_____

April 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS: _____

_____

July 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

August 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

September 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS: _____

_____

October 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

November 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

December 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS: _____

_____

NAME: _____

SE ION IX: CPOC Requested Waiver Services (Budget She · Typical Week Schedule **Confid al**

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

1. Provider Name (Full Name -No Acronyms)	2. Provider Number	3. Service Type	4. Procedure Codes	5. Weekly Number of Units	6. Cost/Units	7. Annual Costs
FORMULA = Column 5 x 52 x Column 6 = Column 7					**ANNUAL TOTALS**	

Provider representative signature:: _____ Agency:_____ Date:_____

PROVIDER REPRESENTATIVE SIGNATURE:
_____ Agency:_____ DATE:_____

*I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATED SERVICES.

BCSS Approval Signature/title _____ **Date** _____

NAME: _____

BCSS-CPOC-NOW

ISSUED 04/28/03

SSN #: _____

CONFIDENTIAL

TYPICAL DAILY SERVICE TOTALS

PROCEDURE CODES (FROM COLUMN 4 ON BUDGET SHEET)	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	WEEKLY TOTALS (UNITS OF SERVICE IN COLUMN 5 OF BUDGET SHEET)

ADDITIONAL UNITS OF SERVICE PER QUARTER – ALTERNATIVE SCHEDULE

PROCEDURE CODES (FROM COLUMN 4 ON BUDGET SHEET)	JANUARY – MARCH		APRIL – JUNE		JULY – SEPTEMBER		OCTOBER - DECEMBER	
	UNITS	DATE/ PURPOSE	UNITS	DATE/ PURPOSE	UNITS	DATE/ PURPOSE	UNITS	DATE/ PURPOSE

*Provider Representative Signature: _____ DATE: _____

*Provider Representative Signature: _____ DATE: _____

*I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATED SERVICES.

BCSS APPROVAL SIGNATURE: _____ DATE _____

NAME: _____

BCSS-CPOC-NOW

ISSUED 04/28/03

Section X: CPOC Recipients

Confidential

Recipients must sign that they attended in the planning meeting.	
PLANNING RECIPIENTS	**Relationship**

_____ _____

CASE MANAGER **Date**

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. 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 have been informed of my rights and responsibilities regarding the HCB Waiver Services and have been given the Rights and Responsibilities Form, BCSS. _____ **(Recipient's/Authorized Representative's Initials)**

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 BCSS and/or a hearing by the DHH Appeals Bureau within 30 days of the approved/denied decision. Contact your BCSS 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 70821-4183.

I have been informed of all state plan services _____ **(Recipient's/Authorized Representative's Initials)**

_____ _____

RECIPIENT'S SIGNATURE/GUARDIAN SIGNATURE **DATE**

_____ _____

WITNESS **DATE**

Reviewed by Case Manager Supervisor Signature/title:_____ **date:**_____

FOR BCSS USE ONLY:

RECIPIENT'S NAME: _____ PROGRAM TYPE: NEW OPPORTUNITIES WAIVER

DATE COMPLETE CPOC RECEIVED IN BCSS RO:

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

BCSS APPROVED CPOC BEGIN DATE: _____ **BCSS approved CPOC End Date** _____

SERVICES APPROVED:

SIGNATURE/TITLE OF BCSS REPRESENTATIVE: DATE:

NAME: _____

PERSONAL OUTCOMES WORKSHEETS
(Required as part of CPOC)

NAME: _____

"My Personal Outcomes" Worksheet

Confidential

	Current Life Situation	CURRENT SUPPORT SITUATION – NATURAL AND PAID (WHAT'S GOING ON THAT SUPPORTS MY DESIRED OUTCOME?)	Current Level of Satisfaction (1 TO 5 SCALE)
Identity – "Who Am I?"			
1. What Goals have I set for myself? 2. Where and with whom do I want to live? 3. What do I want to do for my work? 4. Who is closest to me? 5. How satisfied am I with the services and supports I receive? 6. How satisfied am I with my personal life situation?			
Autonomy – "My Space"			
7. What are my preferred daily routines? 8. Do I have the time, space, and opportunity for the privacy I need? 9. Am I in control of who knows personal information about me? 10. Do my home, work, and other environments support what I want and need to be?			
Affiliation – "My Community"			
11. Do I have access to the place I want to be? 12. Do I participate in what happens in my community? 13. Am I pleased with the type and extent of my interaction with other people in my community? 14. Am I known for the different social roles I play? 15. Do I have enough friends? 16. Am I respected by others?			
Attainment – "My Success"			
17. Are the supports and services I receive the ones I want? 18. Have I realized any of my personal goals?			
Safe Guards – "My Safe Guards"			
19. Am I connected to the people who support me the most? 20. Am I safe?			
Rights – "My Rights"			
21. Do I exercise the rights that are important to me? 22. Do I feel that I am treated fairly?			
Health and Wellness – "My Health"			
23. Is my health as good as I can make it? 24. Am I free from Abuse and Neglect? 25. Do I have a sense of continuity and security?			

1 – NOT AT ALL SATISFIED: AREA DISCUSSED BU NO PLANS TO ADDRESS – NOT AT ALL SATISFIED/NO PROGRESS
2 – NOT VERY SATISFIED: AREA DISCUSSED BUT NO ADEQUATELY ADDRESSED/PLANNED FOR – LITTLE OR NO SATISFACION/PROGRESS
3 – SOMEWHAT SATISFIED: AREA DISCUSSED AND ADDRESSED/PLANNED FOR – SOME SATISFACTION/PORGRESS
4 –SATISFIED: AREA DISCUSSED/PLANNED FOR – MOSTLY SATISFIED WITH NOTICEABLE PROGRESS
5 –VERY SATISFIED: AREA DISCUSSED AND ADEQUATELY PLANNED FOR (I.E., TO MAINTAIN CURRENT STATUS, CONTINUE WITH CURRENT OR ADJUSTED PLAN, ETC.) – VERY SATISFIED AT THIS TIME

NAME: _____

Personal Outcomes Importance and Satisfaction:

Choose how important each Personal Outcome is to you.

Choose how satisfied you are with each Personal Outcome.

For each question, check the box that best describes your answer.

Important Note: Personal and Family Outcomes for families with young children focus on the items and issues that matter most to **families** raising a child with a disability. Utilize the Outcome categories listed below to assist **families** of young children determine their level of satisfaction in each area as applicable.

	Not at All	Somewhat	Very
How important is choosing where and with whom you live?			
How satisfied are you with where and with whom you live?			
How important is it for you to feel respected?			
How satisfied are you with how respected you feel?			
How important is choosing where you work (attend school)?			
How satisfied are you with your work (school) situation?			
How important is being satisfied with your personal life situation?			
How satisfied are you with your personal life situation?			
How important is interacting with other members of the community?			
How satisfied are you with interaction in the community?			
How important is it for you to have intimate relationships?			
How important is choosing your daily routine?			
How satisfied are you with your daily routine?			

Comments:

NAME: _____

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

NAME: _____

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY SUPPORTS AND SERVICES
COMPREHENSIVE PLAN OF CARE REVISION REQUEST FOR NEW OPPORTUNITIES WAIVER (NOW)

REVISION #: _____ ☐ ATTACHED SUPPORTING DOCUMENTATION AS NEEDED

☐ EMERGENCY
☐ ROUTINE
☐ SHARED SUPPORTS

RECIPIENT NAME: _____ CM AGENCY/REGION: _____
MEDICAID #: _____ CM AGENCY PHONE #: _____
ID #: _____ _____
REVISION REQUEST DATE(S): _____
JUSTIFICATION FOR REVISION: _____

1. PROVIDER NAME (FULL NAME)	2. SERVICE PROVIDER #	3. SERVICE TYPE	4. SERVICE PROCEDURE CODE(S)	5. TOTAL TYPICAL SCH. WEEKLY # OF UNITS (+ OR -)	X	6. COST/ RATE PER UNIT	=	7. TOTAL TYPICAL SCH. WEEKLY REVISION PERIOD COSTS (+ OR -)	X	8. # OF WEEKS IN REVISION PERIOD	=	9. TOTAL TYPICAL SCH. REV. PERIOD COSTS (+ And/Or -)
					X		=		X		=	
					X		=		X		=	
					X		=		X		=	

I HAVE REVIEWED THE REVISION REQUEST BUDGET SHEET AND I AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE:	10. TOTAL TYPICAL SCHEDULE REVISION COST (+ AND/OR -)	=
RECIPIENT/GUARDIAN SIGNATURE: _____ DATE: _____	11. TOTAL TYPICAL ALT. SCHEDULE REVISION COST (+ AND/OR -)	=
CASE MANAGER SIGNATURE: _____ INITIALS: _____ DATE: _____	12. TOTAL COMBINED TYPICAL & ALT. SCHEDULE REVISION PERIOD COST (+ AND/OR -)	=
SERVICE PROVIDER'S SIGNATURE: _____ INITIALS: _____ DATE: _____		

FOR BCSS USE ONLY:

APPROVED: _____ DENIED: _____ EFFECTIVE REVISION DATE: _____ CPOC BEGIN DATE: _____ CPOC END DATE: _____

BCSS AUTHORIZED REPRESENTATIVE: INITIALS DATE:

Name: _____

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY SUPPORTS AND SERVICES
COMPREHENSIVE PLAN OF CARE REVISION REQUEST FOR NEW OPPORTUNITIES WAIVER (NOW)

RECIPIENT NAME: _____ **SSN#:** _____

TABLE A: SERVICE(S) & UNITS CURRENTLY APPROVED/RECEIVING THAT WILL CHANGE [PLUS (+) OR MINUS (-)]

PROCEDURE CODE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	WEEKLY TOTALS

SCHEDULED CHANGES IN SERVICE WHICH ARE CONSISTENT WEEKLY AND EXTEND TO THE END OF THE CPOC YEAR.

PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	MONDAY # OF UNITS (+ OR -)	TUESDAY # OF UNITS (+ OR -)	WEDNESDAY # OF UNITS (+ OR -)	THURSDAY # OF UNITS (+ OR -)	FRIDAY # OF UNITS (+ OR -)	SATURDAY # OF UNITS (+ OR -)	SUNDAY # OF UNITS (+ OR -)	TOTAL # OF UNITS OF SERVICE FOR REVISED TYPICAL WEEKLY SCHEDULE # OF UNITS (+ OR -)

ALL OTHER CHANGES THAT DO NOT EXTEND TO THE END OF THE YEAR

			MTH DAY YEAR _____ 1ST PARTIAL QUARTER		MTH/YR _____ MTY/YR _____ 1ST FULL QUARTER		MTH/YR _____ MTY/YR _____ 2ND QUARTER		MTH/YR _____ MTY/YR _____ 3RD QUARTER		MTH/YR _____ MTY/YR _____ 4TH PARTIAL QUARTER		TOTAL ALT. SCHEDULE REVISION COST FOR ALL QUARTERS (+AND/OR-)
PROVIDER NAME (FULL NAME)	SERVICE PROCEDURE CODE(S)	SERVICE TYPE	TOTAL UNITS (+AND/OR-)	DATE/ PURPOSE	TOTAL UNITS (+AND/OR-)	DATE/ PURPOSE	TOTAL UNITS (+AND/OR-)	DATE/ PURPOSE	TOTAL UNITS (+AND/OR-)	DATE/ PURPOSE	TOTAL UNITS (+AND/OR-)	DATE/ PURPOSE	

I HAVE REVIEWED THE REVISION REQUEST BUDGET SHEET AND I AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE:

RECIPIENT/GUARDIAN SIGNATURE: _____ DATE: _____

CASE MANAGER SIGNATURE: _____ INITIALS: _____ DATE: _____

BCSS APPROVAL SIGNATURE: _____ INITIALS: _____ DATE: _____

Name: _____

Issued 11-18-03

Louisiana Department of Health and Hospitals
Bureau of Community Supports and Services
Comprehensive Plan of Care (CPOC)
NOW CPOC Revision Request Form
Instructions

Purpose

The purpose of this form is to document revisions as the needs of the individual change during their CPOC year.

Procedure

REVISION REQUEST FORM PAGE 1 of 2:

Complete the top portion of page 1 of 2 of the *Comprehensive Plan of Care Revision Request for New Opportunities Waiver (NOW)* form following the instructions below:

REVISION #: This indicates how many times during the individual's CPOC year a revision has been submitted to BCSS.

RECIPIENT NAME: The individual's full legal name, last name first, must be on the CPOC – no nicknames.

MEDICAID #: Indicate the person's 13-digit **Medicaid** number. Do not use control card number (e.g., 7770000...).

ID#: The ID# consists of the individual's last name and the last four digits of his/her Social Security number. (e.g., HILL3003)

CM Agency: Write full name of Case Management Agency – no acronyms.

CM Agency Phone #: Indicate the Case Management Agency's phone number, including area code.

☐ **EMERGENCY**: Emergency changes must be submitted within twenty-four (24) hours or the next working day. *This 24 hour submission must be in the form of a completed Revision Request Form, "BCSS-CPOC-NOW-RV", sent via fax to BCSS Regional Office (*This reflects a change in current policy and procedure). Due to the urgent circumstances often surrounding an emergency request, the case manger has five (5) working days from the date of the initial faxed Revision Request Form to obtain and submit a signed (by the individual receiving services, or his/her authorized representative) Revision Request Form to BCSS Regional Office. If the case manager is unable to obtain and submit a signed Revision Request form within the five (5) working days, he/she must notify the BCSS Regional Office in writing of the delay, including a brief explanation of reason(s) for delay. The BCSS Regional Office will approve in writing any extensions of time period for submission of signed Revision Request form. **Examples** of an

Emergency Revision include, but are not limited to unplanned illness, hospitalization, illness of a care giver, death of a care giver, family emergencies, natural disaster, etc. **Direct Service Providers** are responsible for notifying Case Management Agency of any emergency changes as soon as they are aware of them, but no later than twenty-four (24) hours of knowledge of emergency.

☐ ROUTINE: *Routine changes must be submitted within seven (7) calendar days prior to the routine change (This reflects a change in current policy and procedure). Examples of an Emergency Revision include, but are not limited to change of provider agencies, family schedule changes, vacations that were not calculated at the time of the initial/annual CPOC planning process, etc. **Direct Service Providers** are responsible for notifying Case Management Agency of any routine changes as soon as they are aware of them, but no later than twenty-four (24) hours of knowledge of request for routine change.

ATTACHED SUPPORTING DOCUMENTATION AS NEEDED: If the recipient/authorized representative is requesting changes for the remainder of the CPOC year, the change(s) **MUST** be documented in the body of the CPOC. These changes must be reflected in accordance with how the recipient defines or prioritizes his/her personal outcomes/goals, and/or service needs, and submitted with the Revision Request Form (See EXAMPLE 3 - Tim Hill).
This does not change the annual CPOC date.

SHARED SUPPORTS: Check this box if individual is receiving Shared Supports.

REVISION REQUEST DATE (S): This indicates the actual dates for which the revision is being requested. **Note:** BCSS will date stamp Revision Request Form on the date it is received at the BCSS Regional Office.

JUSTIFICATION FOR REVISION: Write the reason for the requested revision in this section and attach additional documentation as needed.

1. **Provider Name**: Name of provider agency to provide requested service (Full Name – no acronyms).

2. **Provider Number**: The provider number assigned to each agency for billing purposes.

3. **Service Type**: Type of service requested (e.g., IFS, Day Hab, Shared Supports, etc.).

4. **Procedure Code**: Billing code assigned to services by Unisys (refer to NOW Provider Manual).

5. **Number of Requested Weekly/Daily Units**: Total Number of additional service units being requested by the individual or family/authorized representative for the specified Revision Request Date(s).

6. **Cost/Units**: Cost per Service Unit assigned to each service (refer to NOW Provider Manual).

Total Weekly/Daily Revision Cost: Total cost of the requested units of service per day/week times (x) number of days/weeks revision is being requested for.

8. **# of weeks in revision period** Enter the total number of weeks the revision is for.

9. **Total typical sch. Rev. period costs (+ and/or -)** Enter the total typical schedule revision costs here that will extend to the end of the year.

10. **Total typical schedule Revision costs (+ or -)** Enter the typical schedule revision costs here.

11. **Total typical alternate Schedule revision cost (+ or -)** Enter the total typical alternate schedule revision costs that will not extend to the end of the CPOC year here.

Total Combined Typical s Schedule and alternate schedule Revision period costs (+ and/or -) Enter the total combined typical and alternate schedule revision period costs here.

Upon completion of the CPOC Revision Request Form, the individual/guardian must sign and date bottom of this form along with Case Manager to indicate agreement with revision in services as outlined.

RECIPIENT/GUARDIAN SIGNATURE and DATE

The recipient/guardian must sign and date the revision request form.

CASE MANAGER SINGNATURE and DATE

The case manager must sign and date he revision request form.

SERVICE PROVIDER'S SIGNATURE and DATE

The service provider must sign and date the revision request form.

BCSS USE ONLY: This section is for BCSS staff only.
Name: Individual's Name (Last Name First) must appear at bottom of each page.

EVISION REQUEST FORM PAGE 2 of 2:

Complete page 2 of 2 of the *Comprehensive Plan of Care Revision Request for New Opportunities Waiver (NOW)* form following the instructions below (IMPORTANT NOTE: Correct Completion of this page is crucial to correct Prior Authorized (PA) input which will ensure correct, timely billing):

ID#: The ID# consist of the individual's last name and the last four digits of his/her Social Security number. (e.g., Hill3003)

TABLE A: **SERVICE(S) & UNITS OF SERVICE CURRENTLY APPROVED/RECEIVING THAT WILL CHANGE**

PROCEDURE CODE: List the procedure code(s) of the service currently approved/received that will change with this revision. Not all currently approved/received services are listed in this section – ONLY list the services, added (+) or subtracted, that will change with this revision.

MONDAY – SUNDAY: List the units of service for each listed Procedure Code **currently** approved/received under day of the week service is received.

WEEKLY TOATALS: Total the number of service units currently approved/received for each Procedure Code listed, and indicate the total under Weekly Totals.

TABLE B: **TYPICAL WEEKLY SCHEDULED CHANGES THAT WILL LAST TO THE END OF THE CPOC YEAR**

PROCEDURE CODES: List the procedure code(s) from Column 4 on page 1 of 2 of the Revision Request Form for **additional (+)** units of service being requested to the end of the CPOC.

List the procedure code(s) from Table "A" above of currently approved/received service(s) that **will not** be received/be **subtracted** (-) as a result of this revision request.

UNITS: List the **additional** units of service being requested under the particular CPOC quarter for which request is being made. Indicate this as an **added,** by marking a plus (+) sign in front of added units of service. List **subtraction** of services by marking a minus (-) sign in front of subtracted units of service.

PURPOSE/DATE: Indicate the purpose for which request/change is being made and the date(s) of requested change(s).

TABLE C: **ALTERNATE SCHEDULE - OTHER CHNAGES THAT WIILL NOT EXTEND TO THE END OF THE CPOC YEAR**

PRODEDURE CODE: List the procedure code(s) from Column 4 on page 1 of 2 of the Revision Request Form for **additional (+)** units of service being requested on a short term basis.

List the procedure code(s) from Table "A" above of currently approved/received service(s) that **will not** be received /be **subtracted** (-) as a result of the short term

changes.

)NDAY – SUNDAY: List the **additional** units of service being requested under days of the week for which request is being made. Indicate this is an **added, permanent** service by marking a plus (+) sign in front of added units of service. List permanent (to end of the CPOC year) **subtraction** of services by marking a minus (-) sign in front of subtracted units of service.

WEEKLY TOTALS: Total the additional (+) units of service being requested on a permanent (to end of CPOC year) basis for each Procedure Code listed, and indicate the total under Weekly Totals with a plus (+) sign in front of this total.

Total the units of service being subtracted (-) as a result of requested changes and indicate total under Weekly Totals with a minus (-) sign in front of this total.

(Add additional pages as needed)

RECIPIENT/GUARDIAN SIGNATURE and DATE

The recipient/guardian must sign and date the revision request form.

CASE MANAGER SINGNATURE and DATE

The case manager must sign and date he revision request form.

SERVICE PROVIDER'S SIGNATURE and DATE

The service provider must sign and date the revision request form.

BCSS APPROVAL SIGNATURE and DATE

The BCSS Regional Office must sign and date the revision request form.

Name: Individual's Name (Last Name First must appear at bottom of each page.

SENSITIVE INFORMATION" FORM

Recipients may wish to restrict sensitive information contained in their CPOC. If a recipient and/or his/her authorized representative expresses that they would like to protect information contained in his/her CPOC, the BCSS Sensitive Information form must be completed (refer to BCSS "Sensitive Information" form in Appendix A of this instruction manual). A copy of this information will be kept in a separate file at the BCSS regional office and case management agency.

FROM: _____

TO: BCSS Regional Office, Region ____

BUREAU OF COMMUNITY SUPPORTS & SERVICES
NEW OPPORTUNITIES WAIVER (NOW)

CONSENT FOR AUTHORIZED REPRESENTATION

_____ _____ _____

Name **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 waiver service evaluation process. I understand that the function of the Authorized Representative is to accompany, assist, and represent me in the waiver evaluation process, and to aid in obtaining all necessary documentation for the agency's evaluation for Home and Community Based waiver services. 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 waiver services evaluation, 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.

Authorized Representative Name 1:

Phone number: Home: _____ Work:

Address:

Authorized Representative Name 2:

Phone number: Home: _____ Work:

Address:

Signature of Recipient: _____

Date: _____

Signature of Witness: _____

Date: _____

Signature of Case Manager: _____

Date: _____

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY PORTS AND SERVICES
TRANSITION "WALK OVER" FOR NEW OPPORTUNITIES WAIVER (NOW)

BCSS AUTHORIZED REPRESENTATIVE: _____ **DATE:** _____

SSN #: _____

DAILY SERVICE TOTALS

CONFIDENTIAL

PROCEDURE CODE FROM COLUMN 4 ON BUDGET SHEET	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY	WEEKLY TOTAL (UNITS OF SERVICE TO COLUMN 5 ON BUDGET SHEET)

ADDITIONAL UNITS OF SERVICE PER QUARTER – ALTERNATIVE SCHEDULE

PROCEDURE CODE FROM (COLUMN 4 ON BUDGET SHEET)	JANUARY – MARCH		APRIL – JUNE		JULY – SEPTEMBER		OCTOBER -- DECEMBER	
	UNITS	PURPOSE	UNITS	PURPOSE	UNITS	PURPOSE	UNITS	PURPOSE

BCSS APPROVAL SIGNATURE: _____ DATE: _____

NAME: _____

NOW Transitional Expense and Planning Approval (TEPA) Request Form

BCSS Regional Office (RO): _____

NOW Applicant: _____ SSN: _____

Projected Move Date: _____ Pre-142 Approval Date: _____

Actual Move Date: _____ Final Approved TEPA date: _____

ICF/MR: _____

Total Estimated Costs: _____ Total Actual Costs: _____

Target Region: _____

Itemized Expense List/Cost

Area	Item	Designated Purchaser's Initials	# of Each Item(s) Requested	Estimated Cost Range	Estimated Cost	Actual Cost Based on Actual Date of Receipt
Living Room	Sofa			$250 - $440		
	Love Seat			$150- $300		
	Chair			$75- $150		
	Coffee table			$50-$70		
	End table(2)			$50 - $80		
	Wall Hangings			$10 - $45		
	Recliner			$140 - $280		
Dining Room	Dining Table/Chairs			$140 - $210		
Bed Room	Bedroom Set: includes mattress/ box spring (3 or 4 pieces)			$250 - $500		
	Chest of drawers			$100 - $200		
	Nightstand			$75 -$100		
	Miscellaneous (bedding- comforter, sheets, pillows; lamps, curtains- hardware; lamp			$100- $300		
Kitchen	Dishes/Plates			$15- $30		
	Glassware			$5- $15		
	Cutlery/Flatware			$15- $30		

Area	Item	Designated Purchaser's Initials	# of Each Item(s) Requested	Estimated Cost Range	Estimated Cost	Actual Cost Based on Actual Date of Receipt
	Microwave			$40- $70		
	Coffee Maker			$10- $20		
	Pots/Pans			$35- $70		
	Miscellaneous (drain board, dishcloths/towels, pot holders, storage containers appliances, food supplies/staple			$50- $300		
Bathroom	Miscellaneous (towels, hamper, shower curtain, personal care items, bath mats)			$50- $150		
Appliances	Washer			$200- $360		
	Dryer			$150- $260		
	Vacuum Cleaner			$35- $70		
	Air Conditioner			$150- $250		
	Miscellaneous (Iron, small kitchen appliances (e.g., can opener, etc., fan)			$25- $75		
Miscellaneous Other	Curtains/rods, cleaning supplies, broom, mop, bucket, food supplies			$100 - $350		
Moving Expenses	Moving Company			$100- $200		
	Cleaners (prior to move; one time only expense)			$25 - $100		
Health and Safety Assurances	Pest Control/ Eradication			$50 -$150		
	Allergen control			$25 -$30		
	Fire Extinguisher			$30 - $40		
	Smoke detector			$10-$20		

Area	Item	Designated Purchaser's Initials	# of Each Item(s) Requested	Estimated Cost Range	Estimated Cost	Actual Cost Based on Actual Date of Receipt
	First Aid Supplies/Kit			$15 $40		
					Total Estimated Costs $_____	Total Actual Cost $_____

BCSS Pre Approved Service Authorization Amount: $_____

BCSS Regional Office Signature _____

Date_____

Case Manager (CM)

Name: _____

Agency: _____

Address: _____

Telephone Number(s): _____

E-Mail Address: _____

_____

_____

CM Signature **Date**

_____

_____

Designated Purchaser's Signature **Date**

_____

_____

Designated Purchaser's Signature **Date**

_____

_____

Designated Purchaser's Signature **Date**

Designated Purchaser	**Designated Purchaser**
Name: _____ _____	**Name:**
Agency: _____ _____	**Agency:**
Address: _____ _____	**Address:**
Telephone Number(s): _____ _____	**Telephone Number(s):**

E-Mail Address: _____	**E-Mail Address:**

Designated Purchaser	**Designated Purchaser**
Name: _____	**Name:**
Agency: _____	**Agency:**
Address: _____	**Address:**
Telephone Number(s): _____	**Telephone Number(s):**
E-Mail Address: _____	**E-Mail Address:**

OCDD Verification of Actual TEPA costs.

This will verify that the OCDD has reviewed the BCSS approved TEPA form for completeness and compliance and verified receipts for actual expenditures.

NOW Participant's Name: _____

Total Dollar Amount Verified by OCDD: _____

_____ _____

OCDD State Office Date

(BCSS Staff Use Only)

FINAL APPROVAL BY BCSS FOR APPROVED TEPA COSTS AS VERIFIED BY OCDD

Total Actual Costs: _____ **Approved** ☐

Disapproved ☐

_____

_____

BCSS Regional Office **Date:**

Note: This form is required for pre-approval and final approval all Transitional Expense Requests.

Reimbursement for NOW Transitional Expenses is time limited and will only be made based on a BCSS approved CPOC reflecting the need for Transitional Expenses and with the TEPA form.

REPLACEMENT PA REQUEST FORM FOR MEDICAID ID CORRECTION

(To be used only when the CPOC has the
Correct Medicaid ID but the PA has an Incorrect #)

Date of Request: ___ / ___ /_____

Agency Name: _____

Agency Region: _____

Medicaid Provider Number: _____

Agency Telephone: _____

Agency Fax: _____

Client Name: _____
(Please Print)

Client SSN Number: _____ - ____ - _____

Existing PA Number: _____

New Medicaid Number: _____

_____ _____
Signature of Requesting Party Date

Please mail request to:

Statistical Resources, Inc.
Case Management
11505 Perkins Road. Suite H
Baton Rouge, LA 70810

DOCUMENTATION FOR AUTHORIZATION OF SHARED STAFF FOR NEW OPPORTUNITIES WAIVER (NOW)

We the undersigned participants of the New Opportunities Waiver (NOW hereby agree to utilize shared supports as identified on our Comprehensive Plan of Care:

SERVICE	PROVIDER AGENCY	UNITS PER WEEK OF SHARED SUPPORT
Individualized and Family Support-Day		
Individualized and Family Support-Night		
Community Integration Development		
Skilled Nursing Services		

NOTE: A copy of each individual's CPOC budget page MUST accompany this signed authorized and the CPOC to be sent to the BCSS Regional Office.

We further understand that we have the right to refuse this service at any time, but must notify the participant with whom services are being shared within a timely and courteous manner, that the sharing of supports will be discontinued. In addition, it is agreed that we must notify our case manager within a timely fashion if we discontinue our shared support.

_____ _____
NOW Participant's Name or Authorized Representative Date

_____ _____
Case Manager's Signature Date

_____ _____
NOW Participant's Name or Authorized Representative Date

_____ _____
Case Manager's Signature Date

_____ _____
NOW Participant's Name or Authorized Representative Date

_____ _____
Case Manager's Signature Date

DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY SUPPORTS AND SERVICES
NEW OPPORTUNITIES WAIVER (NOW)

Assistive Devices Job Completion Form

Instructions: This form is to be used for all requests for Assistive Devices. The Case Manager will complete Section 1 and submit with the CPOC and/or Revision Request, along with 3 detailed and dated bids from providers, to the BCSS Regional Office. Section 2 will be completed by the BCSS Regional Office. Section 3 will be completed by the enrolled service provider/contractor. Section 4 will be completed by the Case Manager and signed by the recipient/guardian. All signatures are mandatory.

SECTION 1	
Recipient's Name:	Medicaid ID #:
Address:	Diagnosis:
Case Management Agency:	Phone #: ( ) -
Address:	Provider #:
Provider of Modification:	Phone #: ( ) -
Address:	Provider #:
Description of Requested Service:	Anticipated Completion Date:
Requested Amount : Funds Available? ☐ Yes ☐ No	Approved Amount: Procedure Code:
Has this equipment been requested through the Medicaid DME Program? ☐ NO Why? _____ ☐ YES Was request denied? ☐ NO ☐ YES (Notice of denial must be attached)	
Provider Agreement Signature:	Date:
Case Management Agency Agreement Signature:	Date:
Recipient/Family Agreement Signature:	Date:

SECTION 2 - BCSS AGREEMENT DETAILS	
Approved Service:	
Procedure Code:	Approved Amount:$
BCSS Signature:	Date of Approval:
APPROVAL OF THE BCSS OFFICE DOES NOT OVERRIDE ANY LIMITS THE INDIVIDUAL HAS ALREADY MET	

SECTION 3 - VERIFICATION OF COMPLETION	
Description of Completed Job:	
Date Job Began:	Date Job Completed:
Does the Job Meet Applicable Building Code? ☐ YES ☐ NO	
Provider's Signature:	Date:
Recipient/Family Signature:	Date:
FORWARD COMPLETED FORM TO THE CASE MANAGER	

SECTION 4 - CASE MANAGER'S VERIFICATION OF COMPLETION	
Date Completed Job Verified:	Job Acceptable?
Comments:	
Case Manager's Signature:	Date:
Recipient/Family Acceptance Signature:	Date:
CASE MANAGEMENT AGENCY SUBMITS TO BCSS AGENT FOR PRIOR AUTHORIZATION (PA) RELEASE	

Assistive Devices Job Completion Form Instructions
New Opportunities Waiver (NOW)

This form is to be used for all requests for Assistive Devices identified in the BCSS approved CPOCand/or Revision Request. Case Manager will complete Section 1, obtain proper signatures, and send along with form CPOC Revision to BCSS Regional Office. Section 2 will be completed by the Regional BCSS Office and sent back to the Case Manager who will forward it to the provider. Section 3 will be completed by the service provider/contractor and returned to Case Manager as soon as job is completed. Section 4 will be completed by the Case Manager, signed by the recipient/guardian to indicate that they have accepted the job, and submitted to the BCSS Regional Office who will the generate MR/DD 14. All signatures are mandatory. All work is to be performed in the current CPOC year approved, or a CPOC amendment must be completed.

Section 1: After the CPOC is approved and the family has agreed upon a provider for the service, this information shall be completed by the Case Manager. The Case Manager will then obtain signatures of service provider/contractors and recipient/family member to indicate agreement of all parties involved. The Case Manager will ensure that the service provider/contractor is aware of building codes. The service provider/contractor will bear the burden of liability with all applicable building codes and licensing requirements in effect for the area of the state in which the work is being performed. If it is a vehicle lift, then only vendors approved to install the equipment are appropriate.

Description of Requested Service:	Case Manager will enter the Procedure Name
Anticipated Completion Date:	Case Manager will enter the anticipated completion date of job as indicated by service provider/contractor.
Requested/Approved Amount:	Case Manager will enter the amount requested for the job. The approved amount is the amount to be encumbered.
Funds Available:	Shows that the recipient does have available funds. Case Manager will contact appropriate BCSS personnel to verify whether or not the recipient has funds available. The Case Manager should also check their records to determine if anything has been previously requested, as not all services may have been billed/paid. It is the Case Manager's responsibility to track this, and the family's responsibility to know if they have utilized their funding.
Procedure Code:	Case Manager will indicate appropriate procedure code for this service.
Agreement Signatures:	Signatures in this section validate that this equipment is a new need, and has not been ordered or currently in the possession of the recipient.
Provider Agreement Signature:	Presence of a signature of service provider/contractor indicates agreement to provide the service, cost, and anticipated completion date.
Case Management Agency Agreement Signature:	Presence of a signature of Case Management Agency representative indicates agreement with the need of the service, cost, and anticipated completion date.
Recipient/Family Agreement Signature:	Presence of a signature indicates approval of the provider, and agreement with the cost and anticipated completion date.

After Section 1 has been completed by Case Manager, the job completion form will be forwarded to BCSS Regional Office for review and completion of Section 2.

Section 2: BCSS Regional office will enter the approved service, procedure code of the approved service and the dollar amount of the approved service. Presence of signature in section labeled "BCSS Agreement" indicates authorization of the requested service and dollar amount payable to contractor for service. BCSS Regional office staff will enter the date of the approval for the service. The individual and family are responsible to know if there are funds available and if services have been utilized. The approval of the BCSS Office does not override any limits the individual has already met.

Section 3: The selected service provider/contractor will complete the following after the job is finished:

Description of Completed Job:	Description of services provided and completed (attach any drawings).
Provider's Signature:	Presence of a signature indicates the job has been completed by service provider/contractor as agreed upon.
Recipient/Family Signature:	Presence of a signature verifies that the job was completed.
Date Job Completed:	Actual Date of Completion
Does the Job Meet Applicable Building Code?:	Service provider/contractor's assurance of compliance with applicable building and licensure standards.

The service provider/contractor will then provide the form with their original signature to the Case Manager who will then view the job with the family and complete Section 4. This form can be faxed to the case manager and the original form mailed to expedite the process.

Section 4: The Case Manager shall complete this section and obtain signature of recipient/family member indicating approval/agreement, and send a copy of the form to the BCSS Regional Office via fax or mail. The completed form must be mailed or faxed to the BCSS Regional Office within ten (10) working days of the date of the actual job completion. After the completed form is received in the BCSS Regional Office, the staff will enter information into P.A. System and the MR/DD 14 will be issued at the next BLAST authorizing payment.

DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF COMMUNITY SUPPORTS AND SERVICES
NEW OPPORTUNITIES WAIVER (NOW)

Environmental Accessibility Adaptation Modifications Job Completion Form

Instructions: This form is to be used for all requests for Environmental Modifications. The Case Manager will complete Section 1 and submit with the CPOC and/or Revision Request, along with 3 detailed and dated bids from providers, to the BCSS Regional Office. Section 2 will be completed by the BCSS Regional Office. Section 3 will be completed by the enrolled service provider/contractor. Section 4 will be completed by the Case Manager and signed by the recipient/guardian. All signatures are mandatory.

SECTION 1

RECIPIENT'S NAME: _____ MEDICAID ID #: _____

ADDRESS: _____ DIAGNOSIS: _____

CASE MANAGEMENT AGENCY: _____ PHONE #: ( )

ADDRESS: _____ PROVIDER #: _____

PROVIDER OF MODIFICATION: _____ PHONE #: ( )

ADDRESS: _____ PROVIDER #: _____

DESCRIPTION OF REQUESTED SERVICES: _____ ANTICIPATED COMPLETION DATE: _____

REQUESTED AMOUNT:: $ _____ FUNDS AVAILABLE? ☐ YES ☐ NO APPROVED AMOUNT: $ _____ PROCEDURE CODE: _____

HAS THIS EQUIPMENT BEEN REQUESTED THROUGH THE MEDICAID DME PROGRAM?

☐ NO WHY? _____

☐ YES WAS REQUEST DENIED? ☐ NO ☐ YES (NOTICE OF DENIAL MUST BE ATTACHED.)

PROVIDER AGREEMENT SIGNATURE: _____ DATE: _____

CASE MANAGEMENT AGENCY AGREEMENT SIGNATURE:: _____ DATE: _____

RECIPIENT/FAMILY AGREEMENT SIGNATURE::

SECTION 2 – BCSS AGREEMENT DETAILS

APPROVED SERVICE: _____

PROCEDURE CODE: _____ APPROVED AMOUNT: $ _____

BCSS SIGNATURE: _____ DATE OF APPROVAL: _____

APPROVAL OF THE BCSS OFFICE DOES NOT OVERRIDE ANY LIMITS THE INDIVIDUAL HAS ALREADY MET.

SECTION 3 – VERIFICATION OF COMPLETION

DESCRIPTION OF COMPLETED JOB: _____

DATE JOB BEGAN: _____ DATE JOB COMPLETED: _____

DOES THE JOB MEET APPLICABLE BUILDING CODE? ☐ YES ☐ NO

PROVIDER'S SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY SIGNATURE: DATE:

SECTION 4 – CASE MANAGER'S VERIFICATION OF COMPLETION

DATE COMPLETED JOB VERIFIED: _____ JOB ACCEPTABLE? _____

COMMENTS: _____

CASE MANAGER'S SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY ACCEPTANCE SIGNATURE: DATE:

CASE MANAGEMENT AGENCY SUBMITS TO BCSS AGENT FOR PRIOR AUTHORIZATION (PA) RELEASE

STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

October 1, 2003

David W. Hood
SECRETARY

Medicaid Administrative Memorandum
Number 31- 2003

TO: Administrative and Agency Personnel

FROM: Ben A. Bearden, Director **/s**
Bureau of Health Services Financing

RE: **People First Language**

It is the policy of Louisiana Medicaid's Eligibility Sections to use "People First Language" and to adhere to the principles below in all written as well as verbal communications.

PEOPLE FIRST LANGUAGE

Language is power. Our words have the power to inspire, motivate and uplift people. They also have the power to hurt, isolate and oppress individuals or entire segments of society. Often times, throughout our history, it has become necessary to change our language and the way in which we refer to individuals and groups to avoid further oppressing those members of society. The time has come to reshape our language once again so that we may refer to people with disabilities and the disability community in a respectful and inclusive manner.

CHOOSING TO USE PEOPLE FIRST LANGUAGE

Generally, in choosing words about people with disabilities, the guiding principle is to refer to the person first, not the disability. In place of saying "the disabled," it is preferable to say "people with disabilities." This way, the emphasis is placed on the person, not the disability.

EXAMPLES OF PEOPLE FIRST LANGUAGE

Many labels used for disabilities in our society have negative connotations or are misleading. Using labels contributes to negative stereotypes and devalues the

person they attempt to describe. Avoid using the following terms when speaking to or about people with disabilities:

invalid	wheelchair-bound	mongoloid	deaf and dumb
defective	special person	handicapped	victim
crippled	suffers from	stricken with	afflicted with
a patient	retarded	mute	

MAKING THE CHANGE TO PEOPLE FIRST LANGUAGE

- "handicapped" or "disabled" should be replaced with "people with disabilities"
- "the handicapped" or "the disabled" should be replaced with "people who have disabilities"
- "he/she is wheelchair bound" or "confined to a wheelchair" should be replaced with "he/she uses a wheelchair"
- "he/she has a birth defect" should be replaced with "he/she has a congenital disability"
- "handicapped" in reference to parking, bathrooms, rooms etc. should be replaced with "accessible"
- "he/she is retarded or MR" should be replaced with "he/she has a cognitive disability or mental retardation"
- "he/she's a Down's or mongoloid" should be replaced with "he/she has Down Syndrome"

GENERAL GUIDELINES FOR TALKING ABOUT DISABILITY

1. Do not refer to a person's disability unless it is relevant to the conversation.
2. Use the word "disability" rather than "handicap" to refer to a person's disability. Never use "cripple/crippled" in any reference to a disability.
3. When referring to a person's disability, use "People First Language."

4. Avoid referring to people with disabilities as "the disabled, the blind, the epileptics, the retarded." Descriptive terms should be used as adjectives, not as nouns.

5. Avoid negative or sensational descriptions of a person's disability. Don't say "suffers from, a victim of, or afflicted with." These negative descriptions elicit unwanted sympathy, or worse, pity toward individuals with disabilities. Respect and acceptance is what people with disabilities prefer.

6. Don't use "normal and "able-bodied" to describe people who do not have disabilities. It is better to say "people without disabilities," if necessary to make comparisons.

APPENDIX B-
Procedure Codes and Rates

NEW OPPORTUNITIES WAIVER SERVICES

Waiver Eligibility Segment Code 0401

SERVICES PROCEDURE CODES/RATES

Effective April 1, 2004

Providers must bill the procedure code that is appropriate for the date of service in which services were rendered.

Provider Type	Local Code (Effective 7/1/03-3/31/04)	MOD	HCBS Waiver Service Description	HIPAA Code (Effective 4/1/04)	MOD	HIPAA Service Description	Units
01 or 82	Z0600		Individual & Family Support-Day	S5125	U1	Attendant Care Services	15 minutes $3.50
01 or 82	Z0601		Individual & Family Support- Night	S5125	UJ	Attendant Care Services	15 minutes $1.75
01 or 82	Z0602		Shared Support, 2 persons– day	S5125	U1 AND UN	Attendant Care Services	15 minutes $2.63
01 or 82	Z0603		Shared Support, 3 persons- day	S5125	U1 AND UP	Attendant Care Services	15 minutes $2.33
01 or 82	Z0638		Shared Support (2P) – night	S5125	UN AND UJ	Attendant Care Services	15 minutes $1.32
01 or 82	Z0639		Shared Support (3P) – night	S5125	UP AND UJ	Attendant Care Services	15 minutes $1.17
02	Z0636		One Time Transitional Service	T2038		Community Transition, Waiver	Lifetime $3,000.00
13	Z0632		Employment Related Training	T2019		Habilitation, Supported Employment	15 minutes $1.63
14	Z0633		Day Habilitation	T2021		Day Habilitation Waiver	15 minutes $1.63
14	Z0634		Day Habilitation Regular Transportation	T2002	U6	Non-Emergency Transportation	Day (Roundtrip) $12.00
14	Z0635		Day Habilitation Transportation - wheelchair	A0130	U6	Non-Emergency Transportation wheelchair	Day (Roundtrip) $20.00
15	Z0616		Environmental Access. (ramp)	Z0616		Environmental Access. (Ramp)	$4,000.00 per recipient; once the recipient reaches 90% or greater of the cap and (Continued)
15	Z0617		Environmental Access. (lift)	Z0617		Environmental Access. (Lift)	
15	Z0618		Environmental Access. (Bathroom)	Z0618		Environmental Access. (Bathroom)	

NEW OPPORTUNITIES WAIVER SERVICES
Waiver Eligibility Segment Code 0401

SERVICES PROCEDURE CODES/RATES
Effective April 1, 2004

Provider Type	Local Code (Effective 7/1/03-3/31/04)	MOD	HCBS Waiver Service Description	HIPAA Code (Effective 4/1/04)	MOD	HIPAA Service Description	Units
15	Z0620		Environmental Access. (Other)	Z0620		Environmental Access. (Other)	the account has been dormant for 3 years, the recipient may access another $4,000.00
16	S5160		PER	S5160		PER (Install & Test)	Initial installation $30.00
16	S5161		PER	S5161		PER (Maintenance)	Monthly $27.00
17	Z0621		Medical Equip. & Supplies (lifts)	Z0621		Medical Equip. & Supplies (lifts)	$4,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient may access another $4,000.00
17	Z0622		Medical Equip. & Supplies (switches)	Z0622		Medical Equip. & Supplies (switches)	
17	Z0623		Medical Equip. & Supplies (controls)	Z0623		Medical Equip. & Supplies (controls)	
17	Z0624		Medical Equip. & Supplies (other)	Z0624		Medical Equip. & Supplies (other)	
44	T1002		RN Services	T1002		RN Services	15 minutes $6.13
44	T1002	U2	RN Services, 2 persons	T1002	UN	RN Services, 2 persons	15 minutes $4.59
44	T1002	U3	RN Services, 3 persons	T1002	UP	RN Services 3 persons	15 minutes $4.04
44	T1003		LPN/LVN Services	T1003		LPN/LVN Services	15 minutes $6.13
44	T1003	U2	LPN/LVN Services, 2 persons	T1003	UN	LPN/LVN Services	15 minutes $4.59
44	T1003	U3	LPN/LVN Services, 3 persons	T1003	UP	LPN/LVN Services	15 minutes $4.03
44, 82, 89	Z0604		Transition Prof. Support Services (psychologist)	H2011	U7	Crisis Intervention Services	15 minutes $18.75
44, 82, 89	Z0605		Trans. Support Services (RN)	H2011	TD	Crisis Intervention Services	15 minutes $6.13

NEW OPPORTUNITIES WAIVER SERVICES

Waiver Eligibility Segment Code 0401

SERVICES PROCEDURE CODES/RATES

Effective April 1, 2004

Provider Type	Local Code (Effective 7/1/03-3/31/04)	MOD	HCBS Waiver Service Description	HIPAA Code (Effective 4/1/04)	MOD	HIPAA Service Description	Units
44, 82, 89	Z0606		Trans. Support Services (LPN)	H2011	TE	Crisis Intervention Services	15 minutes $6.13
44, 82, 89	Z0609		Professional Services-Psychologist	H2017	U7	Psychosocial Rehabilitation Services	15 minutes $18.75
44, 82, 89	Z0610		Professional Services-RN	H2017	TD	Psychosocial Rehabilitation Services	15 minutes $6.13
44, 82, 89	Z0611		Professional Services-LPN	H2017	TE	Psychosocial Rehabilitation Services	15 minutes $6.13
44, 82, 89	Z0612		Professional Services-Social Worker	H2017	AJ	Psychosocial Rehabilitation Services	15 minutes $9.38
44, 82, 89	Z0613		Professional Consultation-Psychologist	H2014	U7	Skilled Training and Development	15 minutes $18.75
44, 82, 89	Z0614		Professional Consultation-Social Worker	H2014	AJ	Skilled Training and Development	15 minutes $9.38
44, 82, 89	Z0615		Professional Consultation-RN	H2014	TD	Skilled Training and Development	15 minutes $6.13
45	Z0637		Case Management	Z0637		Case Management	Monthly
45	Z0177		Case Management – High Risk	Z0177		Case Management	Monthly
82 or 89	Z0607		Community Integration & Development	T2025		Waiver Services	15 minutes $3.50
82 or 89	Z0608		Community Integration & Development, *2 persons	T2025	UN	Waiver Services	15 minutes $2.00
83	Z0625		Center-Based Respite	T1005	HQ	Respite Care	15 minutes $2.87
84	S5140		Substitute Family Care (SFC)	S5140		Foster Care, adult	Day $20.00
89	S5136		Supervised Independent Living (SIL)	S5136		Companion Care	Day $20.00
98	Z0626		Supported Employ (one on one)	H2023		Supported Employment	15 minutes $6.54

NEW OPPORTUNITIES WAIVER SERVICES

Waiver Eligibility Segment Code 0401

SERVICES PROCEDURE CODES/RATES

Effective April 1, 2004

Provider Type	Local Code (Effective 7/1/03-3/31/04)	MOD	HCBS Waiver Service Description	HIPAA Code (Effective 4/1/04)	MOD	HIPAA Service Description	Units
98	Z0627		Supported Employ (follow along)	H2026		Ongoing Support to Maintain Employment	Day $50.00
98	Z0628		Supported Employ (Mobile crew)	H2025	TT	Ongoing Support to Maintain Employment	15 minutes $2.00
98	Z0630		Supported Employ (Regular Transportation)	T2002		Non-Emergency Transportation	Day (Roundtrip) $12.00
98	Z0631		Supported Employment (Transportation-wheelchair)	A0130		Non-Emergency Transportation (wheelchair)	Day (Roundtrip) $20.00

The specified modifier(s) is/are required for this HIPAA code.

Modifiers: Certain procedure codes will require a modifier (or modifiers) in order to distinguish services. The following modifiers are applicable to New Opportunities Waiver (NOW) providers:

AJ = Licensed Social Worker
HQ = Group Setting
TD = Registered Nurse (RN)
TE = Licensed Practical Nurse (LPN)
TT = Individual Service Provided to More than One Person
UJ = Night
U1 = Day
UN = 2 people
UP = 3 people
U6 = Day Habilitation
U7 = Psychologist

7.0 CLAIMS SUBMISSION AND PROCESSING

This section goes through the process of billing for Medicaid Services. When filing for reimbursement of services rendered providers can bill their claims electronically on the 837P format or hardcopy using the CMS 1500 claim form.

7.1 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

7.1.1 Reminders Concerning Electronic Claims Filing

- Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA).
- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.
- The total amount of the submitted file must equal the amount indicated on the Unisys response file.
- To check on a file or report submission of a second file before a 24-hour period has lapsed, call (225) 237-3200, ext. 3244 or 3335. **Please have your EMC submitter ID ready and identify the type of claim you are calling about.**
- To request EMC specifications or EMC enrollment packets, call (225) 237-3303.
- To discuss testing/test transmissions, questions concerning EMC specifications, or electronic remittance advices, call the EDI Help Desk at (225) 237-3318.

7.2 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).

7.2.1 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.

7.2.2 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.

7.2.3 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.

7.2.4 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.

7.2.5 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.

7.2.6 Claims Documentation

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

7.3 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

1. 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 _____

PHYSICIAN OR SUPPLIER INFORMATION

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 MM DD YY

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 MM DD YY

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 (UZ) (12-90)
FORM OWCP-1500 FORM RRB-1500

7.3.1 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.

9A. **Other 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 Referring 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.

7.4 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, 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."

7.4.1 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.

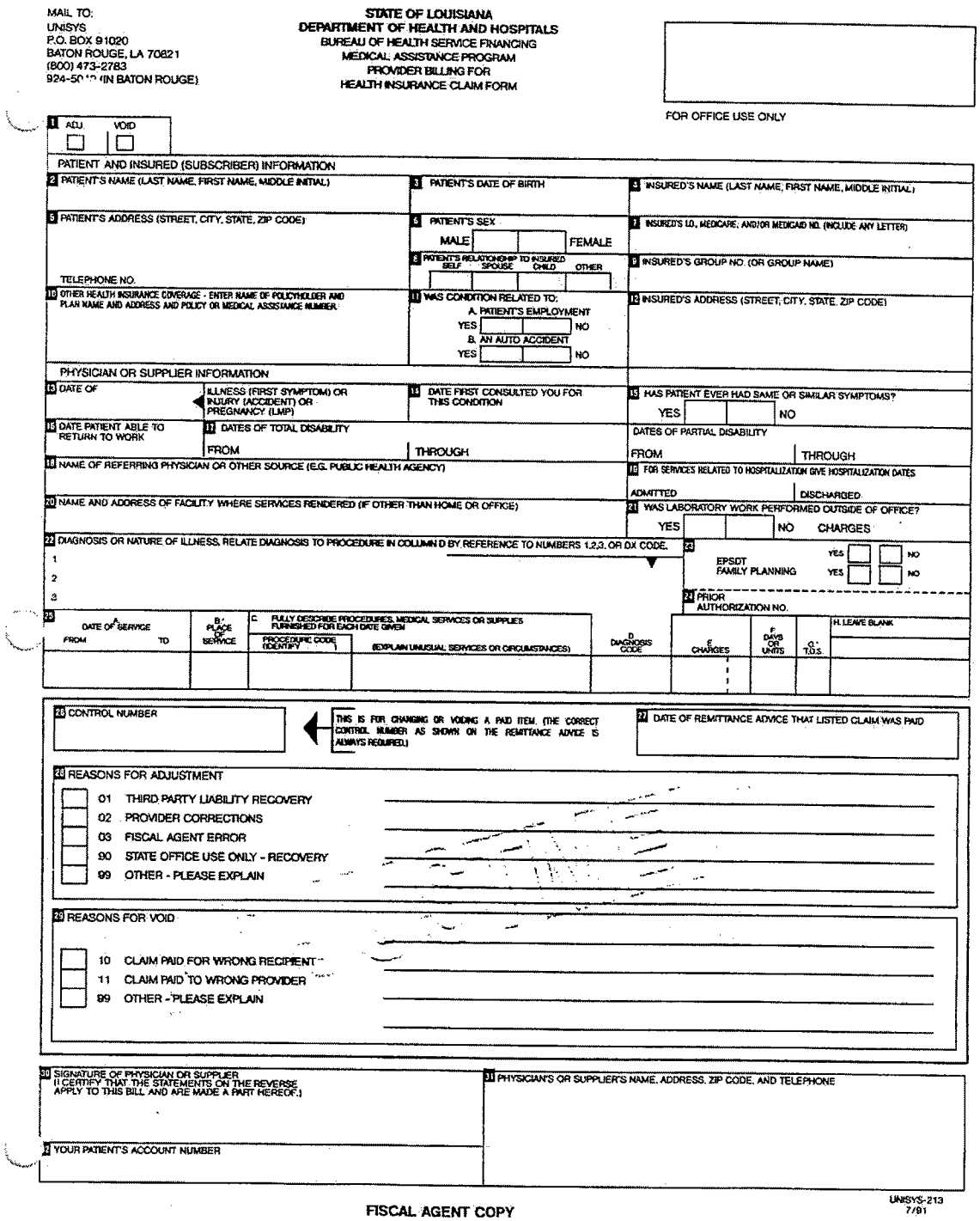
7.4.2 Hard Copy Adjustments and Voids

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.

7.4.3 213 Adjustment/Void Form Sample



MAIL TO:
UNISYS
P.O. BOX 91020
BATON ROUGE, LA 70821
(800) 473-2783
924-50[illegible] (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 INSURED'S I.D. MEDICARE, AND/OR MEDICAID NO. (INCLUDE ANY LETTER)
8 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
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 DX CODE.
1
2
3
23 EPSDT YES NO
FAMILY PLANNING YES NO
24 PRIOR AUTHORIZATION NO.

25 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. T.O.S.	H. LEAVE BLANK

26 CONTROL NUMBER
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 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

29 REASONS FOR VOID
☐ 10 CLAIM PAID FOR WRONG RECIPIENT
☐ 11 CLAIM PAID TO WRONG PROVIDER
☐ 99 OTHER - PLEASE EXPLAIN

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE
32 YOUR PATIENT'S ACCOUNT NUMBER

FISCAL AGENT COPY

UNISYS-213
7/91

7.4.4 Instructions for Completing the 213 Adjustment/Void Form

1.* **ADJ/VOID**—Check the appropriate block.

2.* **Patient's Name**

a. **Adjust**—Print the name exactly as it appears on the original claim if not adjusting this information.

b. **Void**—Print the name exactly as it appears on the original claim.

3. **Patient's Date of Birth**

a. **Adjust**—Print the date exactly as it appears on the original claim if not adjusting this information.

b. **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**

a. **Adjust**—Print the address exactly as it appears on the original claim.

b. **Void**—Print the address exactly as it appears on the original claim.

6. **Patient's Sex**

a. **Adjust**—Print this information exactly as it appears on the original claim if not adjusting this information.

b. **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**

a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.

b. **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**

a. **To Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.

b. **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.

7.5 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.

7.5.1 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.

7.5.2 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.

7.6 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.

7.6.1 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.

7.6.2 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.

7.6.3 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.**

7.7 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.

7.8 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.

7.9 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

7.10 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.

7.10.1 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.

7.10.2 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.

7.10.3 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.

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.

7.10.4 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.

7.10.5 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.

7.10.6 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 or by 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.

7.11 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.

7.11.1 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

LOUISIANA
Department of HEALTH and HOSPITALS
Frederick P. Cerise, M.D., M.P.H.
SECRETARY

July 30, 2004

BCSS-C-04-019
BCSS-P-04-015
BCSS-ADM-04-005

MEMORANDUM

TO: Contracted and Non-Contracted Case Management Agencies
Direct Service Provider Agencies
BCSS Regional Offices

FROM: Barbara C. Dodge, Director

RE: Clarification of Documentation Procedures

This will serve to clarify proper documentation procedures for staff to use in recording activities for recipients of waiver services.

Documentation in case records provides an ongoing "picture" of the progress toward achieving outcomes and the basis for decisions and recommendations for supportive services. For this reason, documentation of activities is not linked to minute increments, but rather describes the activity over a period of time.

While HIPAA requires billing to be recorded in 15-minute increments, this is not necessarily a requirement of documentation. Unless the activity only takes 15 minutes, such as administration of medication, then documentation would cover the period of time the activity took place. Documentation must be completed at the end of each shift for each service delivered.

An example of an adequate progress note would be a shopping trip with the direct support worker to the mall that occurs over a 3 hour time period, where the time is documented in a summary. Staff **would not** be required to document every 15 minutes to describe the ongoing activities. The adequate progress note could be done in a summary, describing the time the person left for the shopping trip, who accompanied them, possibly purchases made, a meal or snack eaten, a movie that was attended, the time they returned home and progress toward their personal outcome. Remember, however, that critical incidents, per BCSS policy, must always be included as a part of documentation.

Documentation is not intended to be intrusive or an embarrassment to anyone. It should describe the quality and quantity of services rendered, as well as provide accountability for the agency.

Kathleen Babineaux Blanco
GOVERNOR

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September 22, 2004

BCSS-ADM-04-006
BCSS-C-04-021
BCSS-P-04-018

TO: **All Medicaid Home and Community-Based (HCB) Waiver Direct Service Providers**

FROM: **Barbara C. Dodge, MA FAAMR**
Director

RE: **Clarification of requirements for HCB Waiver Direct Service Providers regarding Individualized Back Up Plans and Emergency Evacuation Response Plans**

This memo will serve as clarification of requirements for Medicaid HCB Waiver Direct Service Providers regarding Individualized Back Up Plans and Emergency Evacuation Response Plans. HCB Waiver Direct Service Providers are required to have functional Individualized Back Up Plans and Emergency Evacuation Response Plans that are consistent with the participant's Comprehensive Plan of Care (CPOC).

HCB Waiver Direct Service Provider agencies shall possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety outlined in the approved CPOC.

For people with disabilities who need some form of assistance to accomplish life's daily tasks, being without the personal assistance and supports they need can be a frightening and intimidating experience. Without the necessary assistance and supports, the participant's physical and/or emotional health and safety can be negatively impacted. Even worse, the participant may experience loss of dignity, independence and control over his/her life and services. Well thought out backup plans that are prepared before such occasions arise, are not only required, but are essential to the overall well-being, safety and peace of mind of the participant.

Backup plans cover situations that may occur from time to time when direct support workers are absent, unavailable or unable to work for any reason. The participant's Support Coordinator (Case Manager), through a person-centered process, is responsible for working with the participant, his/her family, friends and providers during initial and subsequent annual CPOC planning meetings to establish plans to address these situations. Backup plans must be updated

annually, or more frequently as needed, to assure information is kept current and applicable to the participant's needs at all times.

The Support Coordinator shall assist the participant and his/her circle of support to identify individuals who are willing and able to provide a backup system during times when paid supports are not scheduled on the participant's CPOC. When supports are scheduled to be provided by the direct service provider, providers must have back up systems in Place. It is unacceptable for the Direct Service Provider to use the participant's informal support system (i.e., friends and family) as a means of meeting the agency's individualized backup plan, and/or emergency evaluation response plan requirements. Families and others identified in the participant's circle of support may elect to provide back up but this does not exempt the provider from the requirement of providing the necessary staff for back up purposes.

The backup plan must include detailed strategies and person-specific information that addresses the kind of specialized care and supports needed by the participant, as specified in their individualized Comprehensive Plan Of Care (CPOC).

The agency must have in place policies and procedures that outline the protocols the agency has established to assure that backup direct support staff are readily available, that lines of communication and chain-of-command have been established, and that procedures for dissemination of the backup plan information to participants and Support Coordinators are in place. Protocols outlining how and when direct support staff are to be trained in the care and supports needed by the participant must also be included. Note: Training for workers must occur **prior** to the worker being solely responsible for the support of the participant.

Next, an Emergency Evacuation Response Plan must be developed and included in the participant's CPOC. An Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts. The Emergency Evacuation Response Plan must include at a minimum the following components:

- Individualized risk assessment of potential health emergencies, geographical and natural disaster emergencies, as well as potential for any other emergency conditions;

- A detailed plan to address participant's individualized evacuation needs, including a review of individualized backup plans;

- Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security, establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and

- Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post emergency protocols. Note: Training for direct support staff must occur **prior** to worker being solely responsible for the support of the participant and participants must be provided with regular, planned opportunities to practice the Emergency Evacuation Response Plan.

Due to the requirements of HCBS Waivers to ensure the health and welfare of Waiver participants, Direct Service Providers who are deemed to be out of compliance in the provision of necessary supports will be removed from the Freedom of Choice listing and /or sanctioned up to and including exclusion from the Medicaid Program.

CC: All Case Management (Support Coordination) Agencies
BCSS Regional Offices
BCSS State Office Staff
All Policy and Procedure and Service Manuals

Kathleen Babineaux Blanco
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FROM: **Barbara C. Dodge, MA FAAMR Director**

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MEMORANDUM

TO: Support Coordination and Direct Service Provider Agencies Providing Support to the New Opportunities and Children's Choice Waiver Participants

FROM: Kathy H. Kliebert
Assistant Secretary

SUBJECT: Personal Outcome Measures Training

DATE: January 18, 2006

OCDD will begin offering Personal Outcome Measures (POM) to OCDD Regional Offices, Support Coordination Agencies and Direct Service Providers in March. The following are the trainings that will be offered:

One day "refresher" for:

- People who have had the 2 or 4 day session and want a refresher.
- People who need to know what POMs are, but do not work directly with people supported, i.e., Administrators of Regional Offices, Support Coordination Agencies and Direct Service Provider Agencies and other OCDD staff who would like to know what POMs are all about.

Three day session for:

- People who have never been introduced to the outcomes and need the skills of gathering the information for people supported, i.e., QMRPs, Direct Support Workers, Support Coordinators, Regional Office staff, etc.

  This session is two days in classroom learning and one day meeting with someone in services to gather information about their personal outcomes. Day one and three are classroom and day two is with the person.

In order to effectively plan for these trainings, we need an assessment of your training needs for Personal Outcome Measures. So that we can begin the process of prioritizing the locations and dates the trainings will occur, please complete the attached Training Needs for Personal Outcome Measures. **This information is to be returned via mail, fax or e-mail, no later than Friday, February 10, 2006** to:

Office for Citizens with Developmental Disabilities
Attn: Joyce Louden, Education and Training Manager
P. O. Box 3117
Baton Rouge, LA 70821-3117
Fax: 225-342-8823
e-mail: jlouden@dhh.la.gov

For your information, we will begin scheduling these trainings as follows:

March 8, 2006 and March 9, 2006 – One day "refreshers"
Weeks of March 13, 2006 and March 27, 2006 – Three day sessions

Please be aware that this is the first of many that will be offered and not all agencies/regions will be able to attend these first trainings. The information you provide on the Training Needs form will determine the locations and dates of these sessions. You will receive the official dates, times and locations of these sessions and subsequent sessions as they are scheduled.

Additionally, for your information, we will also be providing Planning Framework training beginning sometime in May. We will be gathering information relative to that training sometime in the near future.

We appreciate your assistance in providing our participants the services they need.

KHK:eb

attachment

Training Needs
For
Personal Outcome Measures

Organization/Agency: _____

Address: _____

Telephone Number: _____ **Region:** _____

E-Mail Address: _____

Contact Person: _____

Check Organization Type:

___Regional Office ___Private Support Coordination Agency

___Direct Service Provider

Indicate the number of people who need to attend a Personal Outcome Measures Session

One Day "Refresher": _____

Three Day: _____

Return to:

Office for Citizens with Developmental Disabilities
Attn: Joyce Louden, Education and Training Manager
P. O. Box 3117
Baton Rouge, LA 70821-3117
FAX: 225-342-8823
e-mail: jlouden@dhh.la.gov

Kathleen Babineaux Blanco
GOVERNOR

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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.