PCA WAIVER SERVICES

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Bureau of Health Services Financing

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INTRODUCTION

OVERVIEW

The Personal Care Attendant (PCA) Waiver Program is a Medicaid Home and Community Based Services Waiver providing personal care attendant services instead of institutional care to persons who meet certain disability standards.

This Provider Manual specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is an amalgamation of Federal and State laws and Department of Health and Hospitals policy which govern care to such individuals in the State of Louisiana.

These regulations are established to insure minimum compliance under the law, equity among those served, provision of authorized services, and proper fund disbursement. Where there is a conflict between these regulations and the Federal and State laws which govern provision of and reimbursement for such services, those laws take precedence.

This manual is intended to provide a PCA waiver provider with the information necessary to fulfill its vendor contract with the State of Louisiana and is the basis for Federal and State reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with Federal and State laws and Department rules.

The Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) is responsible for insuring provider compliance with these regulations.

The Licensing and Certification Division of the Department of Social Services determines compliance with State licensing requirements.

Waiver services to be provided are specified in the Plan of Care (BHSF Form PCA 5) formulated by the Interdisciplinary Team, recorded by the case manager, and approved by the Bureau's Health Standards Regional Office. The Plan of Care (POC) contains all services and activities involving the client, non-waiver as well as waiver. Recipients are to receive only those waiver services included in the POC and approved by Bureau of Health Services Financing Regional Office.

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the federal Health Care Financing Administration.

Each person admitted to the waiver occupies a "slot", a reserved place in the waiver. Slots are filled on the basis of greatest need, as determined by a formula involving likelihood of institutionalization, degree of disability, available support, etc. Waiver participants are eligible for all Medicaid services under the State Plan, even if they would not have been eligible for Medicaid without the waiver.

LEGAL BASIS

Home and Community Based Waiver services are authorized under Section 1915(c) of the Social Security Act. The Personal Care Attendant Program is initially effective July 1, 1992 for a three year period.

DEFINITIONS

Agency — The legal entity enrolled to provide services under the approved PCA Waiver. Both public and private agencies are eligible to provide waiver services.

Administrator — An individual whose agency is licensed by the State of Louisiana, who is engaged in the day to day administration and management of a provider agency under this waiver.

Applicant — Refers to an individual whose written application for Medicaid has been submitted to the appropriate eligibility determination agency but whose financial and/or medical eligibility for waiver services has not yet been determined.

Attending Physician — Refers to a physician, currently licensed by the Louisiana State Board of Medical Examiners, who is designated by the beneficiary or responsible party as being responsible for the direction of the recipient's overall medical care, if the beneficiary requires medical supervision under this waiver.

Beneficiary — Person who is entitled to receive services. Waiver beneficiaries are eligible for both waiver and regular Medicaid services. Medicaid beneficiaries, unless they are also determined eligible for the waiver, are not automatically eligible for the waiver.

Bureau of Health Services Financing — The division within the Department of Health and Hospitals which is responsible for administering the Title XIX Program (Medicaid).

Caregiver The person employed by the provider agency responsible for providing services to the waiver beneficiary.

Case Management An organized system by which recipients are evaluated as to individual needs and appropriate services are defined and authorized within certain program limitations. Recipient needs are identified, an Interdisciplinary Team composed of appropriate professionals is convened (staffing), and a plan of care is formulated from which services are authorized.

Case management is a necessary tool in the management of services under this waiver.

Certification

Provider Approval following inspection/approval by the Medicaid agency or its agent required to participate as a provider of Medicaid services. This term applies specifically to certain institutions and a limited number of agencies. Providers under this waiver are not required to be certified.

Recipient This term signifies that a determination has been made that an individual meets all requirements for waiver eligibility.

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

Classification of Care Same as Level of Care

Classification of Care Determination See Level of Care Determination

Client An applicant for or a beneficiary of Title XIX funding (Medicaid).

Deinstitutionalized	Entered the waiver from an institution. If the individual entered the waiver before the end of the next calendar month after Medicaid payment was made for institutional care, that individual is considered to have been deinstitutionalized for federal reporting purposes.
Department of Health and Hospitals	The state department responsible for Title XIX (Medicaid) in Louisiana.
Department of Health and Human Services	The federal agency responsible for administering the Medicaid Program.
Diverted	Entered the waiver from home, or from care not provided in an institution. This term denotes the intake status for federal reporting purposes of an individual who was not in an institution during the month prior to entering the waiver.
Enrollment	The process of executing a contract with a potential provider for participation in the Medicaid program. Enrollment includes determination that the potential provider meets the requirements outlined in this document, the execution of a provider agreement and assignment of the provider number used for payment. See Section 4 for further details.
Fiscal Intermediary	The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. The fiscal intermediary processes Title XIX (Medicaid) claims for services and issues appropriate payment.
HCFA 372	Annual report of institutional and waiver costs submitted by the Medicaid agency to the Health Care Financing Administration to demonstrate cost effectiveness of the waiver.

Health Care Financing Administration

The Federal agency within Department of Health and Human Services responsible for the administration the Medicare Program and overseeing and monitoring the state's Medicaid program.

Health Standards Section

The section within the Bureau of Health Services Financing responsible for the licensing of long term care providers. Health Standards regional office personnel also determine whether requirements for classification of care and plan of care criteria are met, and conduct Utilization Reviews.

Individualized Planning

Intake, eligibility determination for case management services, interdisciplinary assessment process (which disciplines and services best address the recipient's needs), integrating spoken and written information, managing and resolving conflict, establishing rapport with the individual and family including personal contact and supportive counseling.

Institution

An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor (derived from the definition of institution found in 42 CFR 435.1009).

Interdisciplinary Team

A team comprised of the provider agency case manager, client, providers of other services if deemed appropriate, medical and social work professionals as necessary, client's family, and advocates, who determine appropriate goals and services to be provided. For medical and social work professionals, participation may be by report.

Level of Care Determination

The decision made by BHSF regional office staff as to whether the applicant meets the medical requirements for appropriate institutional services. Also called classification of care determination. Each waiver applicant must meet nursing facility level of care criteria in order to participate. Unless subsequent information indicates that the client no longer meets level of care criteria, the BHSF regional office original determination stands indefinitely.

Annual redeterminations of level of care are performed by the provider, and reviewed by BHSF regional staff during the semi-annual Utilization Review. Additional information on the client's condition (at a minimum, Form 90-L is reviewed annually by the provider to determine whether the recipient's condition continues to meet NF level of care criteria. If level of care is questionable, the information is forwarded to BHSF Regional Office for a level of care determination.

Licensure

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

Medicaid

Medical assistance provided under the State Plan approved by the Health Care Financing Administration under Title XIX of the Social Security Act, and under approved waivers of the provisions of that law.

Medicaid Agency

The single state agency responsible for the administration of the Medicaid Program. In Louisiana, the Department of Health and Hospitals is the single state agency.

Medicaid Management Information System

The computerized claims processing and information retrieval system which includes all providers eligible for participation in the Medicaid Program. This system is an organized method for payment of claims for all Title XIX services.

Nursing Facility — An institution certified by BHSF as a nursing facility which services persons requiring skilled or intermediate classifications of care. An ICF/MR facility is not a nursing facility.

Personal Care Attendant Services — Assistance rendered to a disabled person by a caregiver consisting of assistance with or performing tasks necessary to the disabled person's wellbeing. Such assistance is rendered by a caregiver who is an employee of a licensed PCA agency. For purposes of this waiver, the agency must be enrolled in the Medicaid Program as a Waiver PCA provider.

Plan of Care — The coordinated integrated treatment plan developed for each applicant/beneficiary by the Interdisciplinary Team. The provider agency develops a comprehensive plan of care including both waiver and nonwaiver services and goals. This plan includes medical, social, and educational services to be accessed, as appropriate to the client's needs and interests.

Provider — Any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid Program.

Provider Agreement — A contract between the provider of services and the Louisiana Department of Health and Human Resources, Office of the Secretary, Bureau of Health Services Financing. The agreement specified responsibilities with respect to the provision of services and payment under the Title XIX Medicaid Program.

Recipient — Any individual who has been determined eligible for Title XIX (Medicaid), whether or not Medicaid reimbursement is made for services. If a beneficiary is a minor or if the beneficiary has been interdicted in a court of competent jurisdiction, the term "recipient" means the legal guardian or the curator of record. The term "recipient" also means "responsible party", when the beneficiary has designated such a person in writing.

Regional Health Standards Section Unit — A team of Bureau of Health Services Financing professional staff responsible for review functions in the waiver, and the determination of the medical necessity for classification of care for Medicaid applicants/beneficiaries.

Responsible Party — Any individual designated to act as an official delegate or agent. In the case of an interdicted individual, the responsible party shall be the curator appointed by the court of competent jurisdiction. In the case of a minor, the responsible party is the individual or legal entity who is legally responsible for the recipient, usually the parent or legal guardian. For a non-interdicted adult, "responsible party" shall mean that individual designated in writing by the beneficiary as the individual to act on his/her behalf.

Room and Board — Costs associated with rent, utilities, food, and related items. Room and board are not included in reimbursement for waiver services. Room and board expenses are offset by the recipient's own income.

Service Coordination — Translating clinical findings into services, determining which services and connections are needed, learning generic and specialized settings in the community, negotiating with service providers, observing and monitoring recipient progress and the services provided, communicating with providers and recipients including training ordered by the ID Team, linking recipients to services that meet their needs, being aware of resources (Food Stamps, SSI, Medicaid, etc.).

Skilled Nursing Facility — A facility providing a level of care characterized by a need for intensive monitoring on a twenty-four hour a day basis. This term continues to be appropriate for a facility so designated by Medicare. For Medicaid purposes, the terms "Intermediate Care Facility" and "Skilled Nursing Facility" have been replaced by the term "Nursing Facility". Reimbursement to nursing facilities is based on a patient-specific Level of Care or Classification of Care.

Slot

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

Slots are allocated by Bureau of Health Services Financing State Office. When all slots are filled, each provider maintains a waiting list which is used to fill vacated or additional slots as they become available. Vacant waiver slots are filled on the basis of greatest need as determined by criteria described in this document. Waiver participants shall not be supplanted or replaced by more recent applicants with greater need, however.

Staffing

A joint meeting of the applicant/recipient, interested parties, and the provider agency's staff members and/or consultants involved in planning and implementing the overall plan of care. This meeting is also referred to as a meeting of the Interdisciplinary Team (see the definition of Interdisciplinary Team).

Title XIX

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

Unit of Service

Time unit which constitutes one payment unit. For purposes of this waiver, a unit is thirty minutes. A unit may not be billed unless at least 15 minutes of service has been performed.

Utilization Review

Semi-annual review of provider records, and of other documentation necessary to determine that the beneficiary continues to meet level of care and plan of care criteria. At a minimum, medical evaluations and plan of care must be current (i. e., less than 12 months old).

Waiver

An exception to the Title XIX statutory requirements to provide for Home and Community Based Services. Services provided under a waiver differ in amount, duration, or scope from services provided under the state's Title XIX State Plan, and are available in lieu of institutional care. Client eligibility for waiver participation is determined by a separate process that Medicaid eligibility under other regulations.

ABBREVIATIONS

BHSF	Bureau of Health Services Financing, the division of the Department of Health and Hospitals responsible for the administration of the Title XIX (Medicaid) program in Louisiana
CFR	Code of Federal Regulations
DHH	Louisiana Department of Health and Hospitals, the State department responsible for the administration of the Title XIX (Medicaid) program in Louisiana
DHHS	Department of Health and Human Services, the Federal agency responsible for the administration of the Title XIX (Medicaid) program
FI	Fiscal Intermediary, the contractual entity responsible for activities in conjunction with claims payment for Medicaid services
HCFA	Health Care Financing Administration, the Federal agency within DHHS responsible for the administration of the Title XIX (Medicaid) program
HSRO	BHSF Health Standards Section Regional Office
HSS	Health Standards Section, the section of the Bureau of Health Services Financing responsible for approval of plans of care and classification of care determinations
IOC	Inspection of Care
MMIS	Medicaid Management Information system
NF	Nursing Facility
PCA	Personal Care Attendant
POC	Plan of Care
UR	Utilization Review

PROVIDER ENROLLMENT

Waiver services are provided by licensed Personal Care Attendant agencies enrolled in the Medicaid program as Waiver PCA providers specifically to provide services under this waiver.

ENROLLMENT AS MORE THAN ONE TYPE OF SERVICE PROVIDER

Providers under this waiver may separately enroll to provide any other services which they are qualified to provide. For each service the provider wishes to provide, application must be made separately, and all requirements fulfilled. Providers enrolled to provide more than one service are issued a separate provider number for each type of service.

LICENSURE

Each provider of waiver services must be licensed by the State to provide personal care attendant services. A copy of the license must be provided by the applicant. If retroactive enrollment is desired, license(s) for the entire retroactive period must be provided.

Providers must be licensed according to the requirements for Client Care Provider - Personal Care Attendants Service Module.

DISCLOSURE OF OWNERSHIP

Each potential provider agency shall submit form OMB No. 0936-0086, "Disclosure of Ownership and Control Interest Statement" as a part of the application process. See sample letter at the end of this section. A copy of this form will be included in the enrollment packet furnished by BHSF Provider Enrollment.

PROVIDER AGREEMENT

Each waiver service provider must enter into a provider agreement with the Bureau of Health Services Financing. The agreement requires that providers adhere to regulations, including the requirements contained in this Provider Manual. The provider entity shall authorize a representative to enter into this agreement. The PE-50 is the form to be used. A copy of this form will be included in the enrollment packet furnished by BHSF Provider Enrollment.

PROVIDER APPLICATION PROCESS

A copy of the enrollment packet may be obtained from:

Bureau of Health Services Financing
Provider Enrollment Section
P.O. Box 91030
Baton Rouge, Louisiana 70821-9030

The completed forms are submitted to the same address. If further information is required for enrollment, the applicant provider will be notified.

NOTIFICATION OF PROVIDER ENROLLMENT

Applicant providers will be notified in writing when an enrollment decision has been made. Notification of provider enrollment includes assignment of an exclusive provider number to be used in submitting claims. Providers enrolled to provide more than one service are issued a separate provider number to be used in billing for each type of service.

RECIPIENT ELIGIBILITY

Services under this waiver are restricted to individuals who:

1. Are disabled according to Medicaid criteria. If the client is SSI-eligible, he/she is deemed to have met this requirement. If not SSI-eligible, a disability determination must be made as part of the financial eligibility process.

2. Meet Level of Care criteria for Nursing Facility level of institutional care.

3. Are between 18 and 55 years of age when admitted to the waiver. Those attaining higher ages will be permitted to continue in the waiver as long as continuous certification is maintained.

4. Have lost sensory or motor functions to such an extent that they require assistance with personal care needs, domestic or cleaning needs, dressing and undressing, moving into and out of bed, ambulation, and related services.

5. Require at least fourteen hours a week of personal assistance, which services are necessary and sufficient to prevent or remove the client from placement in an institutional setting.

6. Are capable of directing the activities of the person providing the services.

7. Have gross income less than 300% of the SSI amount.

8. Meet other income and resource limitations applicable to individuals institutionalized in a nursing facility.

Only individuals meeting these criteria will be considered for Personal Care Attendant Waiver services. Waiver eligibility is available to a limited number of beneficiaries, restricted by the Personal Care Attendant waiver agreement with the Health Care Financing Administration. Applicants who meet all the criteria above shall be ranked by degree of need using the formula described later in this section. Those with the highest scores fill the slots allocated to the provider in their area in that order. Subsequent new or vacated slots will be filled by applicants having the highest scores at the time the unoccupied slot becomes available.

IN GENERAL

All recipients of PCA waiver services must have been determined financially and medically eligible to be recipients of waiver services. A chart describing the process (including form numbers) is included at the end of this section.

CASE MANAGEMENT

Case Management is an integral part of the PCA waiver service. This service shall be performed by the PCA provider, who is responsible for formulating the comprehensive plan of care and coordinating both waiver and non-waiver services. Case management is considered essential to ensure the safety and well-being of the waiver recipient, since the service is provided in lieu of institutional care. Therefore, if a client chooses not to receive the services of the case manager, waiver services are not available for that client.

FINANCIAL ELIGIBILITY

Financial eligibility is determined by eligibility staff using processes and criteria similar to those used to determine financial eligibility for institutional services in a Nursing Facility.

Complete Financial Determination

Financial eligibility determination must be made for all waiver applicants except those going directly from institutional placement to waiver participation.

If the waiver applicant is an SSI recipient or an AFDC recipient (both are Medicaid eligible), or is a non-recipient living at home, a complete financial eligibility decision must be made.

Determination of financial eligibility includes the categorical relatedness requirement of disability. See "Disability" below.

Eligibility Process When Applicant Is In An Institution

Applicants for waiver participation must meet the medical eligibility criteria for Nursing Facility institutional care (either Intermediate level or Skilled Nursing level). However, persons meeting the definition of Developmentally Disabled may be institutionalized either in a Nursing Facility or in an ICF/MR.

If the waiver applicant is institutionalized (in a NF at the Intermediate Care or Skilled Nursing level or in an ICF/MR), financial eligibility has already been established.

Applicants in a NF must have plan of care approved. The plan of care and supporting documentation must be submitted to Health Standards Regional Office for this determination.

Applicants in an ICF/MR must have classification of care approved for NF eligibility, and plan of care approved. A new form 90-L recommending NF level of care must be included with documentation for the change in classification of care.

The eligibility worker will change type case and notify the recipient of waiver eligibility when the appropriate approval process has been completed.

Disability

All waiver enrollees must meet the categorical requirement of disability as part of the financial eligibility process. SSI beneficiaries are deemed to have met this requirement. If the waiver applicant does not receive SSI and is not in an institution, a disability determination must be made.

The eligibility worker will submit medical information for this requirement. This medical determination is made by the Medical Eligibility Determination Team and is separate and apart from the determination of classification of care made for waiver eligibility.

Earliest Date of Eligibility

Eligibility is effective on the date requested on Form 148 or 148-HCB provided that date is the same as or later than the date that the Interdisciplinary Team compiled the plan of care. Reimbursement is not available for waiver services provided before the plan was formulated, since all waiver services must be provided according to the plan of care. It is assumed that Form 90-L must be completed prior to the ID team meeting. If form 90-L was completed after staffing, the earliest date of waiver eligibility is the later of the date on the 90-L or the date of the staffing.

Retroactive Medical Eligibility (RME)

If the applicant received at least one medical service (any service that would have been paid for if he/she was a Medicaid recipient) at any time during the three months before the earliest date of waiver eligibility, the applicant may be eligible to receive up to 3 months retroactive eligibility for coverage of regular Medicaid services (not waiver services) if he/she was otherwise eligible. Certification for retroactive eligibility is not automatic. The recipient must request retroactive eligibility determination from the eligibility worker and meet applicable requirements.

INITIAL CLASSIFICATION OF CARE DETERMINATION

Waivers, by definition, are an alternative to institutional care. It is required that all waiver applicants must meet the requirements of the classification of care that the applicant would need if institutionalized. To be a participant in this waiver, the applicant must meet NF requirements.

The provider is responsible for collecting the materials necessary to make this determination, and convening the ID team to formulate the plan of care which documents all services to be arranged, including PCA under the waiver.

This documentation is submitted to the HSRO for a decision as to whether the client meets the criteria for NF institutionalization. Evaluations of classification of care are conducted by the same personnel and in the same manner for institutional and waiver services.

Forms to be submitted for initial Classification of Care determination are:

- Form 148 or 148-HCB giving requested first date of waiver service
- Form 90-L completed 90 days or less before date waiver service is requested for (usually the date of ID team meeting), with physician's recommendation for LOC and available documentation of condition
- PCA 5 (Plan of Care)
- Cover Sheet identifying program applied for

DETERMINATION OF CONTINUED ELIGIBILITY

Recipient eligibility must be redetermined at least annually.

Disability Determination

Waiver recipients who do not receive SSI must have redetermination of disability completed at intervals as required by the Medical Eligibility Review Team. Both the disability determination and a financial eligibility determination will be completed at the same time whenever possible. The eligibility worker will notify the beneficiary by letter when redeterminations are necessary.

Financial Eligibility Determination

Periodic redeterminations of financial eligibility for waiver services will be conducted. The beneficiary will be notified by letter when redeterminations are necessary. The maximum length of time allowed between redeterminations is one year.

Plan of Care and Classification of Care Review

The plan of care and medical documentation must be less than 1 year old at all times. It is suggested that an annual redetermination date be set by the provider, with required elements updated at the same time to insure that all requirements are met timely.

Utilization Review by HSRO is held every six months at the provider agency's place of business to review individual case records. The purpose is to determine whether the client continues to meet level of care criteria, and whether documentation is current. The review team may interview clients, inspect records, or any other activity necessary to determine whether services provided are adequate and appropriate.

An entrance conference will be held at the beginning of the review to inform the agency of expectations. An exit conference will be held at the end of the review to orally report findings. A written report of findings will be issued. Providers may be required to take corrective action, or may be sanctioned as the result of the review.

At a minimum, the following documentation will be reviewed.

Plan of Care

A complete staffing resulting in a thorough review of the plan of care must be held at least annually, and the results filed in the recipient's record. There must be documentation that a staffing was held, such as Form PCA 4. There must be a current (less than 1 year old) POC in the case record at all times. Reviews of the POC must be held at least quarterly to determine that services continue to be appropriate and adequate.

Physical Examination

A complete annual physical examination is required. The results may be recorded on Form 90-L, or on another form of the physician's choice. The information provided must be adequate to document the client's physical condition. The physical examination is considered current for one year.

CHANGES

Income and Resources

Changes in a recipient's income or resources must be reported to the eligibility worker as they occur. Failure to timely report such changes may result in consequences to the client, including recoupment and/or prosecution.

Plan of Care

The POC must be promptly amended to reflect changes. Additions may be appended when additional services are authorized, and deletions made by striking out information no longer pertinent. These should be dated and initialed by the case manager in accordance with instructions. Substantiative changes may require a completely new plan. Case record documentation should explain the need for the changes. Changes in the plan of care are reviewed by Health Standards Section during the semi-annual Utilization Review. Interim changes are not to be submitted to Health Standards Section for approval.

Client's Physical Condition

Upon significant change in the client's medical condition, the provider shall obtain a new Form 90-L with physician's current recommendation. Failure to continue to meet LOC criteria will result in waiver ineligibility. Discovery of significant improvement at UR could result in retroactive ineligibility of the client and recoupment of payment for unnecessary services.

ALLOCATION OF SLOTS

Participation in the waiver is available to a limited number of clients. The approved waiver document authorizing Medicaid payment for the program establishes those limitations.

Number of Slots

Current approval is for the following number of slots:

Year 1	20 clients
Year 2	22 clients
Year 3	24 clients

Initial Allocation

Slots are initially allocated among the three providers who have expressed an interest in serving this population as follows:

NORIL	10 slots
New Horizons	5 slots
SLIC	5 slots

Initial Ranking of Applicants

Ranking of applicants is according to scores on the Degree of Need form included in Appendix A. Those with the highest scores fill the slots allocated to the provider in their area in the order of greatest need as determined by the ranking instrument. In instances of the same score, date of expressed in interest will be controlling.

Process for Filling New or Vacated Slots

Subsequent new or vacated slots assigned to that provider will be filled by applicants meeting eligibility criteria who have the next highest scores.

Slot Allocation if New Providers Apply

If additional licensed Personal Care Attendant providers are enrolled as waiver providers, allocation of subsequent vacant slots shall be on the basis of greatest need on a statewide basis. BHSF State Office will assign subsequent vacant or new slots to the client with the highest score at the time that the vacancy or creation of new slots occurs, regardless of the providing agency involved.

SERVICE DESCRIPTIONS

IN GENERAL

Personal care attendant (PCA) services are services performed by a caregiver that will meet the needs of beneficiaries whose disabilities preclude the performance of certain independent living skills related to the activities of daily living, such as bathing, dressing, grooming, food preparation and storage.

DESCRIPTION OF SERVICES

PCA services to be reimbursed under this waiver shall be limited to:

- Assisting with personal hygiene, dressing, bathing and grooming.
- Performing or assisting in the performance of tasks related to maintaining a safe, healthy and stable living environment such as:
  - Light cleaning tasks in areas of the home used by the recipient.
  - Shopping for such items as health and hygienic products, clothing and groceries.
  - Performing activities of daily living inside and outside the home which require attendant care.
  - Assisting with or performing beneficiary laundry chores.

- Assisting the beneficiary in transfer and/or ambulation in those activities which are necessary to live independently.
- Assisting with bladder and/or bowel requirements or problems, including help with bed pan routines.
- Assisting in the storage of foods and the preparation and eating of meals.
- If indicated, accompanying beneficiaries to clinics, physician's offices, and other appointments.
- Assisting the beneficiary to receive any service specified in the written plan of care, including leisure skills development which are specified in the service plan of care.
- Communicating to the case manager any changes in the recipient's condition.
- Assisting in activities which would enhance the individual's employability.

SERVICE LIMITS

Providers of this service will be reimbursed for each approved unit of service provided. In instances where more than one family member is waiver eligible and receiving concurrent PCA services provided by the same caregiver, separate billing for each household member is permissible. A unit of service for PCA services will be one-half hour. At least fifteen minutes of service must be provided to bill for a unit of service. A maximum of 1,825 hours (3,650 half-hour units) per beneficiary per year may be reimbursed under this waiver.

GENERAL REGULATIONS

ADEQUATE PERSONNEL

The provider shall maintain staffing adequate to serve clients accepted for services.

RECIPIENT ABUSE

The provider shall report, within 24 hours, any suspected or actual abuse of a recipient by anyone. Such report shall be made to BHSF regional Health Standards Section staff.

PAYMENT IN FULL

The provider shall accept as payment in full the amounts paid in accordance with established fees for services billed. The provider may not bill the beneficiary or other party for services reimbursed under Title XIX.

CHARGING FOR SERVICES TO NON-MEDICAID CLIENTS

Providers submitting claims for services provided to Medicaid beneficiaries shall not furnish services free of charge to other (non-Medicaid) clients. Services to other clients may be furnished according to a sliding fee schedule, which may include an income limit below which no fee is levied. Documentation of such fee schedule and determination of amount of fees shall be maintained by the provider for compliance purposes.

VOTER INFLUENCING

No payments for case management services shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition of any election ballot or proposition of matters having the effect of law being considered by the legislature or any local governing authority.

RECORD KEEPING

The provider shall maintain all records required by licensing requirements. The following records are required for waiver purposes, and are kept in the client's individual case record. Certain documentation specified below that is more than six (6) months old may be maintained in an inactive file which is available for review. Inactive file case records shall be individual specific records.

Documentation in both active and inactive case records shall be available for review.

Plan of Care

The provider shall maintain a current plan of care in the active case record at all times. Evaluations, reports, and other documentation upon which the plan of care is based shall be available either in the active or inactive record.

Services Provided

The waiver provider shall keep sufficient records to document provision of services.

Records shall document the date, time period, and service provided. Recording shall include progress notes concerning observations of the client's condition, progress, or other pertinent information. A simple record-entry system maintained in the client's case record in sufficient.

Authority to Perform Services

Copies of current form 51-NH notifying the provider that services are authorized shall be maintained in the client's active case record. Previous forms 51-NH may be filed in the inactive case record.

Incident Reports

Copies of incident reports and subsequent correspondence concerning the incident shall be filed in the active case record until six (6) months after the incident. Incident reports older than six (6) months old may be filed in the inactive record if desired.

Organization of Records

The organization of recipient records shall be in a manner which encourages staff to use them as a communication tool. This means that the location of documents shall be consistent among records and that all records shall be appropriately thinned so that current materials are easily located in the record.

Records Entries and Corrections

Any error made by the staff in a recipient's record shall be corrected using the legal method which is to draw a line through the erroneous information, write "error" by it and initial the correction. Correction fluid shall not be used in recipient records.

All entries made by staff in recipient records shall be legible, fully dated, legibly signed and include the functional title of the individual.

Review by State and Federal Agencies

The waiver provider shall make all necessary recipient records available to appropriate state and federal personnel at all reasonable times.

Availability of Recipient Records to Staff

The waiver provider shall ensure that recipient records are available to staff directly involved with the recipient's care.

Protection of Records

The waiver provider shall protect records against loss, damage, destruction, and unauthorized use.

Confidentiality of Information

The waiver provider shall safeguard the confidentiality of recipient information. The waiver service provider shall release confidential information only under the following conditions:

- By court order; or

- By the recipient's written informed consent for release of the information unless such consent is contradicted as documented in the recipient's record by the attending physician. In such cases, the individual to whom the recipient's rights have devolved shall provide informed written consent.

Retention of Records

The waiver service provider shall retain records for whichever of the following time frames is longer:

- Until records are audited and all audit questions are answered; or

- Three (3) years beyond the end of each waiver period. The waiver period is the approved period that a waiver is in effect. The initial waiver period is three years, and will end on June 31, 1995. If the waiver is renewed, the anticipated waiver period is five (5) years and will end June 31, 2000.

CASE MANAGEMENT

Case management is essentially service coordination used to inform the client of available services and alternatives, and assist in accessing services to meet identified needs.

In the PCA waiver, case management is a function of the Personal Care Attendant provider agency. Cost of providing the service are not separately billed, but is included in the rate for personal care attendant services as overhead expense associated with provision of the service. The requirement for case management is in addition to the PCA licensing requirements for provider staffing and plan of care.

CASE MANAGER QUALIFICATIONS

The employee(s) of the Personal Care Attendant waiver provider performing the function of case manager must be:

1. An individual with at least a bachelor's degree in a human service related field plus two years of experience in such a field.

2. Years of experience in human service related field may be substituted for the bachelor's degree on an equivalent basis of one year of experience for 30 hours of course credit.

3. 30 hours or more graduate level course credit in the human services field may be substituted for one year of the experience.

SINGLE CASE MANAGER

Each client shall have one person assigned as case manager. A case manager may serve more than one client.

REFERRALS

Appropriate referrals for services are made and documented for each recipient.

PROFESSIONAL CONSULTATION

Appropriate professional consultation is available to each case manager at all times.

SERVICE DESCRIPTION

Individualized Planning *

Examples are:

- Development on an initial service plan which identifies the evaluations necessary to determine the recipient's service needs. This activity refers to preparatory actions which are necessary prior to provision of actual case management services rendered from the comprehensive service plan.

  If, at the time that the recipient first presents to the agency or soon thereafter (prior to convening of the Interdisciplinary Team), there exists a crisis, the case manager may, under this activity, make appropriate referrals even though no comprehensive service plan has been developed. This provision in no way negates the responsibility of the case management agency to convene the Interdisciplinary Team and develop a comprehensive service plan.

- Arrangements for and compilation of interdisciplinary team or other evaluative materials.

- Coordination and participation in the development of a comprehensive service plan for each recipient which includes both formal and informal (those provided by family, friends, and volunteers) services.

* see definitions

Service Coordination *

Examples are:

- Training and support of the recipient in the use of personal and community resources identified on the care plan.
- Advocacy on behalf of recipients so that they may receive appropriate benefits or service. Negotiating with other service providers comes under the general category of advocacy.
- Periodic reassessment of the recipient's services to insure that they continue to meet the individual's needs.
- Maintenance of documentation of each service provided to a recipient.
- Monitoring service delivery in order to assess progress, the quality of services, and that the services are being provided as ordered by the ID Team.

* see definitions

ACTIVITIES NOT CONSIDERED CASE MANAGEMENT

Certain activities which are sometimes considered the province of case managers are not, under Medicaid regulations, considered case management. Specific acts which do not fall under the general classifications above are not considered case management services. Examples of such activities are:

- Case finding - advertising or otherwise "beating the bushes" in a search for recipients who meet eligibility requirements.
- Developing placement resources - designing or otherwise investing substantial periods of time in hands-on building of a service designed to meet the needs of recipient(s).
- Legislative advocacy - advocacy for recipients in general or for disabled groups does not meet the case management definition of allowable advocacy activities. Allowable advocacy activities consist of actions on behalf of a specific recipient.
- Counseling - therapeutic problem-solving designed to change interpersonal attitudes, etc. are counseling services not included as case management services, as opposed to situation-specific approaches which may come under case management auspices.
- Training - teaching skills constitutes performance of a service other than case management.

COMPREHENSIVE PLAN OF CARE

General Description

All services are provided according to an individual, comprehensive, written plan of care which is reviewed and updated periodically. Each plan must be a result of an interdisciplinary staffing in which the beneficiary, case manager, and appropriate professional personnel participate.

The plan shall specify the frequency of each approach/service, including the number of days and time of scheduled service each week as appropriate.

The plan of care is documented on Form PCA 5.

Caregiver's Role

The caregiver shall cooperate with the case manager and ID team in developing the Plan of Care, if requested. The caregiver may participate as a member of the ID team.

Availability

Each Plan of Care must be kept in the recipient's individual record.

The care plan shall be easily available to all staff directly involved in providing care to the recipient.

Review and Revision of Care Plan

The care plan shall be reviewed and revised by the ID Team as required by changes in the recipient's condition and/or needs. Minor interim changes, such as a slightly different approach to meet an identified need when the original approach is no longer available, may be made by the case manager and client alone.

Changes to the care plan are made by striking through incorrect or inappropriate material, and by adding new wording. Changes shall be initialed by the case manager and dated. An entry in the client's record shall describe the change and the reason it was necessary.

At least annually, a complete review must be done. Revision and updating must be done at least quarterly. Attendance by the ID team may be by report. The client's record shall document that ID team members attended the staffing by report. Attendance at the staffing may be recorded of Form PCA 4 or another similar form of the provider's choice. The caregiver may participate in review and revision of the care plan at the discretion of the provider agency.

Approval of the Care Plan

Approval of the original plan of care and subsequent changes rests with the Bureau of Health Services Financing Health Standards Regional Office. The initial decision regarding approval is forwarded to the provider via Form 51-NH. Changes, amendments, adjustments, and new plans are reviewed semi-annually at Utilization Review.

BUREAU OF HEALTH SERVICES FINANCING MONITORING

PLAN OF CARE APPROVAL

Approval of the original plan of care and subsequent changes rests with the Bureau of Health Services Financing Health Standards Regional Office. The initial decision regarding approval is forwarded to the provider via form 51-NH. Changes, amendments, adjustments, and new plans are reviewed semi-annually at Utilization Review.

INCIDENT REPORTS

Separate identifiable written reports of incidents involving waiver beneficiaries shall be prepared when such incidents result in injury or potential injury to the client. The report shall be submitted to BHSF regional Health Standards section.

UTILIZATION REVIEW

Semi-annual Utilization Review of documentation in the provider's records shall be conducted using Form 51-Combined. The waiver provider shall cooperate with HSRO staff in Utilization Review activities.

Provider Responsibilities

The waiver provider shall cooperate in the review when requested by:

- Promptly providing all necessary documents needed for review;
- Providing adequate space and privacy for the Team to review records uninterrupted;

- Assisting with the identification and/or location of individual beneficiaries;
- Insuring that at least six (6) months of current information is included in the active recipient records;
- Arranging for pertinent personnel to attend the Exit Conference, if requested.

Review Reports

Submission The HSRO staff conducting any review or investigation of a provider shall prepare a review report whether or not any deficiencies were identified during the review or investigation. A copy of each report shall be submitted to Health Standards State Office within 30 days of the exit conference.

Content This report shall:

- Carefully track the content of the Exit Conference if identified during a Utilization Review. If deficiencies were omitted from the exit conference, the provider shall be notified by telephone of the omission(s) and the deficiencies shall be included in the review report;
- Cite the specific requirement for which the provider was found deficient;
- State the number of times each deficiency was found;
- State for each deficiency if it was cited during the most recent UR or as a result of complaint investigations, or HCFA surveys.

- Cite the provider agency if any beneficiaries were identified who no longer require services or for whom level of care could not be determined.

- State whether a follow up review will be conducted.

- State what action will be recommended by the Team as a result of the inspection.

- Contain the following paragraph:

  "These deficiencies represent areas in which it has been determined to be functioning below the minimum acceptable standards set by the State of Louisiana. Your failure to implement effective corrective action measures promptly could jeopardize your participation in the Title XIX program."

- Exemplary practice on the part of case management or waiver service provider staff may be cited by the Team but such statements shall be specific and not contradict findings of deficiency. Similarly, improvement shall be specifically defined and shall be supported by a numerical analysis of the Team's findings.

Request for Corrective Action Plan

Negative findings as the result of a UR or complaint investigation require that the provider prepare a corrective action plan. If the provider's corrective action plan is not received within 30 days of the date of the review report, the HSRO LTC Coordinator shall send a certified letter to the provider which requests a response within fifteen (15) days of the date of the follow up letter.

If the provider has not responded to the review report within the 15 day time frame, HSRO will contact State Office.

Receipt and Review of Corrective Action Plans

Within ten (10) working days of receipt by the LTC Coordinator, the provider's corrective action plan shall be reviewed by the LTC Coordinator or designee.

After both the individual and general corrective action plans have been reviewed by the LTC Coordinator, a determination shall be made as to whether the corrective action plan submitted by the provider is sufficient.

Components of an Acceptable Corrective Action Plan

Corrective action plans shall document the provider's anticipated course of action designed to correct the deficiencies found. The plan shall be specific to identified problems. Timeframes for accomplishing goals shall be specified.

Insufficient Corrective Action Plans

If any area of a provider's corrective action plan is determined to be insufficient, the LTC Coordinator shall write a letter to the provider requiring a new corrective action plan for each area which was found to be insufficient. This letter shall request a response from the provider within fifteen (15) days of the date of the letter.

Failure to Respond

The failure of the provider to respond to this letter or an insufficient response shall result in the application of sanctions.

Follow-Up Reviews

When a UR review results in a determination that serious deficiencies exist and/or a provider is substantially out of compliance, a follow-up review shall be conducted between fifteen (15) and forty-five (45) days after the inspection to determine if adequate corrective action has been taken by the provider.

The follow-up review shall involve only those areas in which the provider was found deficient. However, deficiencies not previously cited which come to the Team's attention shall be cited.

RECIPIENT RIGHTS

FREEDOM OF CHOICE The provider shall insure that each beneficiary has freedom of choice with regard to receipt of services and choice of providers.

VOLUNTARY PARTICIPATION A beneficiary will not be forced to receive services for which he or she may be eligible.

CIVIL RIGHTS Providers shall operate in accordance with Titles VI and VII of the Civil Rights Act of 1964, as amended and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. This means that individuals are accepted and that all services and facilities (waiting rooms, toilets, etc.) are available to persons without regard to race, color, religion, age, sex, or national origin.

GRIEVANCES/ FAIR HEARINGS The provider shall establish procedures through which beneficiaries may present grievances which may arise from the operation of the program and/or services provided. The provider shall advise beneficiaries of this right and of their rights to appeal any denial or exclusion from the program or failure to recognize a recipient's choice of a service and of his/her right to a fair hearing. In the event of a fair hearing, a representative of the provider shall appear and participate in the proceedings.

PARTICIPATION IN CARE Each beneficiary shall be provided the opportunity to participate in each interdisciplinary staffing meeting and any other meeting involving services to be provided.

FINANCIAL STANDARDS

Budgets and cost reports are used in setting and adjusting rates. Rates are based on a prospective negotiated fee for service and adjusted in accordance with OMB Circular A-87 for public providers.

PAYMENT PROVISIONS

PROVIDER MANUAL COMPLIANCE

Vendor payment for services provided is dependent upon the provider's compliance with the provider manual.

OVERPAYMENTS

In the event that BHSF determines certain costs which have been reimbursed to the provider are not allowable, BHSF shall have the right to recoup and/or set off and/or withhold said amounts from amounts due the provider under this agreement for costs that are allowed.

REFUNDS DUE

Provider in Non-participatory Status

Vendor Payment which may be made for services performed while a provider is in a non-participatory status shall be refunded to the Office of Management and Finance. The refund shall be made payable to "Office of the Secretary: Medicaid Program."

Correcting Overpayments

A currently participating provider shall correct overpayment billing errors through the use of the appropriate adjustment void form.

INCORRECT OR INAPPROPRIATE CHARGES TO RECIPIENTS

When DHH determines that a provider has violated a provider agreement by incorrectly or inappropriately charging a beneficiary or responsible party, a sum not to exceed the inappropriate charges shall be withheld until the provider:

- Makes restitution to the beneficiary/responsible party; or
- Submits evidence of restitution to Bureau of Health Services Financing and the fiscal intermediary.

COST REPORTS

ANNUAL COST REPORT

Within 90 days of the end of the state fiscal year, each provider must submit a properly completed cost report to BHSF showing actual expenditures for expenses associated with provision of services. This report shall include the same items necessary for the preliminary budget. All budgets shall include at least the following classifications of costs and explanation of cost basis:

- anticipated number of beneficiaries
- anticipated number of units of service per beneficiary
- primary provider staff salaries including benefits
- support staff salaries and benefits
- supervisory/administrative/monitoring salaries and benefits
- ID team costs
- travel expenses
- telephone/mail expenses
- other operating expenses
- overhead (office space costs)
- training costs
- percentage of costs attributable to Title XIX clients

The BHSF Non-residential Cost Report Form shall be used to report these anticipated costs.

If the cost report is not submitted as required, a penalty of five percent (5%) of the total monthly payment for each month of non-compliance may be levied. BHSF may grant one 31-day extension of the 90 day limit upon request of the provider if good cause has been shown for the delay. This penalty may be increased by five percent (5%) for each succeeding month of non-compliance.

"Good cause" shall be synonymous with a good reason or justifiable purpose in seeking an extension. A "good cause" is one that supplies a substantial reason, one that affords a legal excuse for delay, or an intervening action beyond the provider's control. The following shall not be considered "good cause":

- Ignorance of the requirement;
- Hardship or inconvenience;
- A cost report preparer engaged in other work.

COST REVIEWS AND AUDITS

Cost reviews and/or audits shall be conducted based on allowable cost in accordance with the guidelines prescribed by the Provider Reimbursement Manual - HIM 15 not to exceed limitations established by BHSF.

CLAIMS SUBMISSION

HOW TO SUBMIT CLAIMS

Claims must be submitted to the fiscal intermediary for payment.

Claims may be submitted manually on HCFA 1500 billing form, or submitted by Electronic Media Claims (EMC) submission. Claims must be received by the fiscal intermediary within one year of date of service in order to be processed.

A Remittance Advice (RA) form explaining each claim line (payment, non-payment, error codes, etc) is returned with remittance.

PROVIDER RELATIONS UNIT

Unisys/Louisiana Medicaid has a Provider Relations Staff ready to assist providers with any questions they may have. There are individuals in the Baton Rouge office whose primary responsibility is to respond to telephone inquiries. These individuals can be reached at the following telephone numbers:

Baton Rouge Providers (504)924-5040

Providers Outside of Baton Rouge 1-800-473-2783
(Louisiana Providers Only)

Telephone service is available Monday through Friday from 8:00 a.m. to 5:00 p.m.

In addition, providers can mail written inquiries to the following address:

Attention: Provider Relations
Unisys/Louisiana Medicaid
P.O. Box 91024
Baton Rouge, La. 70821

Provider Relations also has a staff of Provider Representatives who are available to help providers with billing problems and to help train new staff members. To request a visit with a Provider Representative, providers can call or write to Provider Relations.

NOTE: Written inquiries should contain a note or letter explaining the nature of the problem. Inquiries submitted without explanations could be processed without additional consideration.

In addition, providers who are calling Unisys, Provider Relations, should telephone the Provider Relations switchboard, not the main Unisys switchboard.

RECIPIENT ELIGIBILITY INQUIRIES

Enrolled providers may access recipient eligibility information by touchtone telephone. A toll-free call to 1-800-766-6323 connects the provider with an automated system capable of communicating whether a client is eligible on a specific date. Entry of a valid 7-digit provider number is requested by the system in order to access this information.

EMC CLAIMS SUBMISSION

EMC is the submission of claims via computer. Claims can be sent for processing on a diskette (3 1/2", 5 1/4", or 8"), on tape (reel-to-reel), or by telecommunications (modem). EMC runs on any IBM-compatible PC and billing agencies are available.

For more information or to request EMC specifications, please contact the EMC Coordinator:

UNISYS/Louisiana Medicaid
8591 United Plaza Blvd.
Suite 100
Baton Rouge, Louisiana 70809
ATTN: EMC Coordinator
(504) 924-7051

SYSTEM EDITS

The following programming edits have been entered into the claims processing system. Claims which do not conform to these requirements will be denied, and the Remittance Advice (notification to the provider) will show an appropriate edit code for the denied claims.

- Duplicate claims (same recipient, same provider, same service) will be denied.

- Providers may only bill the procedure code applicable to the service for which they are enrolled. Claims with procedure codes for another type of service will be denied.

- Providers who render more than one type of service have a separate provider number for each type of service. Only the procedure code(s) appropriate for the provider enrolled under the provider number listed in item 33 on the claim form will be payable.

- If the client has insurance which will pay for the service, the insurance payment must be shown on the claim, and Medicaid will pay the difference between the insurance payment and the allowable Medicaid payment. A copy of the insurance Explanation of Benefits must be attached to the claim form.

- Only a limited number of units per calendar year are reimbursable. Units of service in excess of the maximum will be denied.

HCFA 1500 BILLING INSTRUCTIONS

FOREWORD

The HCFA 1500 is the only acceptable claim format. The forms may be purchased from a local printer, and are available in packages of 100. Effective April 1, 1992, a revised HCFA 1500 dated 12-80 will be required. Items on that issue are slightly renumbered, and no written description of the service is entered.

Instructions should be carefully followed for accurate and prompt processing of the claim.

When a provider finds it necessary to file a paper copy claim to the Medicaid Program, the HCFA 1500 must be completed in accordance with the instructions that follow.

1.		Check the box that says "Medicaid" (Medicaid #)
1a.	Insured's ID Number	Enter the client's thirteen (13) digit Medicaid ID number exactly as it appear on the recipient's monthly Medical ID card. In the case of a family, make certain that the last two (2) digits of the identification number are the correct individual suffix for the family member who is the case management client. If the number does not match the patient's name in blocks 1-3, the claim will be denied. If this item is blank, the claim will be returned to the provider.
2.	Patient's Name	Enter in this space the name of the client - last name, first name, middle initial. Spell the name exactly as it appears on the client's Medical ID card.
3.	Patient's Birth Date and Sex	Enter the patient's date of birth as reflected on the Medical ID card using six (6) digits (MM DD YY). If there is only one digit in a field, precede that digit with a zero. Put an X in the appropriate box to indicate sex.

4.	Insured's Name	Leave this space blank.
5.	Patient's Address	Enter the client's permanent address.
6.-20.		Not required - you may leave these spaces blank.
21.	Diagnosis	All claims must contain a medically accepted description of the diagnosis. You must enter the numeric code and literal description. Use of ICD-9-CM coding is mandatory.

The following are some appropriate codes in the form acceptable to the claims processing system:

045	Acute poliomyelitis
138	Late effects of poliomyelitis
265.1	Other and unspecified manifestations of thiamine deficiency (includes Wernickies syndrome)
334	Spinocerebellar Disease (Includes Friedreich's Ataxia)
334.4	Cerebellar ataxia in diseases classified elsewhere
334.8	Other spinocerebellar diseases
334.9	Spinocerebellar disease, unspecified
335	Anterior horn cell disease
335.2	Motor neuron disease
335.8	Other anterior horn cell diseases
335.9	Anterior horn cell disease, unspecified
336	Spinal Cord Diseases
336.1	Vascular myelopathies
336.2	Subacute comtined degeneration of spinal cord in diseases classifed elsewhere
336.3	Myelopathy in other diseases classified elsewhere
340	Multiple Sclerosis
342	Hemiplegia
342.1	Spastic hemiplegia
342.9	Hemiplegia, unspecified

343	Cerebral Palsy
343.4	Infantile hemiplegia
343.8	Other specified infantile cerebral palsy
343.9	Infantile cerebral palsy, unspecified
344	Quadraplegia
344.1	Paraplegia
344.2	Diplegia of upper limbs
344.3	Monoplegia of lower limb
344.4	Monoplegia of upper limb
344.5	Unspecified monoplegia
344.6	Cauda equina syndrome
344.8	Other specified paralytic syndromes
344.9	Paralysis, unspecified
359	Muscular dystrophies and other myopathies
359.1	Hereditary progressive muscular dystrophy
359.2	Myotonic disorders
359.3	Familial periodic paralysis
496	Chronic airway obstruction (COPD)
714	Rheumatoid arthritis and other inflammatory polyarthropathies
952.00	Cervical Injury
952.9	Spinal Injury

Up to 4 diagnoses may be entered. Diagnosis codes may be found on the form 51-NH.

22. **Medicaid Resubmission Code** — Leave this space blank.

23. **Prior Authorization** — Leave this space blank.

24.A.	Date of Service	Services may be billed for one day on each line, or they may be span dated, so that services for several days may be billed on one line. Date of service may thus be entered "7/1/92 - 7/7/92". Span dating for a week at a time is a suggested. Documentation supporting the units of service billed must be maintained in the client's record.
B.	Place of Service	Code 4 (Patient's Home) is the only acceptable place of service code.
C.	Type of Service	Leave this space blank.
D.	Procedure Code	A five digit alpha/numeric code for each service is required. The only acceptable procedure code is Z0010. Coding by provider is mandatory.
E.	Diagnosis Code	Not required.
F.	Charges	Enter the product of unit cost times number of units.
G.	Days or Units	Enter the number of half-hour units billed.
H.-K.		Leave these spaces blank.
25.	Federal Tax ID No.	Leave this space blank.
26.	Your Patient's Account Number	If you enter your patient's account (medical record) number, it will appear on your Remittance Advice. It may consist of letters and/or numbers and may be a maximum of thirteen (13) positions.
27.	Accept Assignment	Leave this space blank. Medicaid does not make payments to the recipient. Claim filing indicates acceptance by the provider.

28.	Total Charge	Total all charges listed on the claim. If more than one claim form is used, total each form separately and do not carry forward the total charge.
29.	Amount Paid	Leave this item blank.
30.	Balance Due	Leave this item blank.
31.	Signature of Physician/Supplier	The claim for must be signed. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the provider or the provider representative. If Item 25 is left blank, or if the stamped or computer generated signature is not initialed, the claim will be returned to the provider.
	Date	Enter date of signature.
32.	Name and Address Where Services Were Rendered	Leave this item blank.
33.	Physician's or Medical Assistance Supplier's Name, Address, Zip Code and Telephone Number and Provider ID No.	Enter the provider's name, address, and Medical Assistance Provider Number. This number must be entered in the space adjacent to "Grp. No." This is a seven digit number.

ADJUSTING A CLAIM

GENERAL INFORMATION

- The UNISYS-213 form is used to adjust or void a claim that has previously been submitted on the HCFA-1500. As of the date this manual was printed, the adjustment form had not been modified to correspond to the 12/90 HCFA 1500 renumbering.

- Only a paid claim can be adjusted or voided.

- If you are adjusting a paid claim you may never change the Provider Identification Number or the Recipient/Patient Identification Number.

- When multiple lines are billed on a claim form, the Adjustment/Void form allows the adjustment or voiding of only one line on one Adjustment/Void form. If you need to adjust or void more than one claim line on a multiple line claim form, a separate Adjustment/Void form is required for each claim line.

- Complete the information on the adjustment form exactly as it was on the original claim changing only that item or items that were in error and giving the reason for the changes in the space provided.

- If you are voiding a paid claim enter all of the information from the original claim exactly as it appears on the original claim. After voided claim has appeared on your Remittance Advice, you may resubmit an original claim giving all of the correct information that should appear on that claim.

- When your Adjustment/Void form has been processed, it will appear on your Remittance Advice under either Approved or Denied Claims. The original claim which you have adjusted or voided will appear directly beneath the original claim. If you have voided a claim, the void will show zero for the payment amount. If you have adjusted a claim, all the corrected information will appear. This enables you to link the original and the void or adjustment together.

- A Void/Adjustment will generate Credit and Debit Adjustments which will appear in the Remittance Summary on the last page of the Remittance Advice. In this case, debit and credit refer to the debit against the Medicaid Program and a credit against the Medicaid Program. Debit and Credit in this instance do not refer to the provider.

ADJUSTMENT/VOID FORM INSTRUCTIONS

Block 1. ADJ/VOID

Check the appropriate box.

Block 2. Patient's Name

Adjust - Enter the name exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the name exactly as it appeared on the original invoice.

Block 3. Patient's Date of Birth

Adjust - Enter the date exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the name exactly as it appeared on the original invoice.

Block 4. Insured's name

Adjust - Enter the name exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the name exactly as it appeared on the original invoice.

Block 5. Patient's Address and Telephone Number

Adjust - Enter the address and telephone number exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 6. Patient's Sex

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 7. Insured's ID, Medicaid Number

Adjust - You cannot change an ID Number when adjusting, you must void the invoice.

Void - Enter the number exactly as it appeared on the original invoice.

Block 8. Patient's Relationship to Insured

Block 9. Insured's Group Number

Block 10. Other Health Insurance Coverage

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting the information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 11. Was condition related to:

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting the information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 12. Insured's Address

Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice.

Block 13. Date of:

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 14. Date First Consulted You for This Condition

Adjust - Enter the date exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the date exactly as it appeared on the original invoice.

Block 15. Has Patient Ever Had Same or Similar Symptoms?

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 16. Date Patient Able to Work

Adjust - Enter the date exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the date exactly as it appeared on the original invoice.

Block 17. Date Of Total Disability - Date of Partial Disability

Adjust - Enter the dates exactly as they appeared on the original invoice if you are not adjusting this information.

Void - Enter the dates exactly as they appeared on the original invoice.

Block 18. Name of Referring Physician or Other Source

Adjust - Enter the name exactly as it appeared on the original invoice if you are not adjusting the name.

Void - Enter the name exactly as it appeared on the original invoice.

Block 19. For Services Related to Hospitalization Give Hospitalization Dates

Adjust - Enter the dates exactly as they appeared on the original invoice if you are not adjusting this information.

Void - Enter the dates exactly as they appeared on the original invoice.

Block 20. Name and Address of Facility Where Service Rendered (if other than home or office).

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 21. Was Laboratory Work Performed Outside Your Office?

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 22. Diagnosis or Nature of Illness

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 23. EPSDT Referral

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 24. Attending Physician

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 25. A through F

Adjust - Enter the information exactly as it appeared on the original invoice if you are not adjusting this information.

Void - Enter the information exactly as it appeared on the original invoice.

Block 26. Date of Remittance Advice that Listed Claim was Approved

The correct Control Number as shown on the Remittance Advice is always required.

Block 27. Date of Remittance Advice that Listed Claim was Paid

Block 28. Reasons for Adjustment

Check the appropriate box if applicable and write a brief narrative that best describes why this adjustment is necessary.

Block 29. Reasons for Void

Check the appropriate box if applicable and write a brief narrative that best describes why this void is necessary.

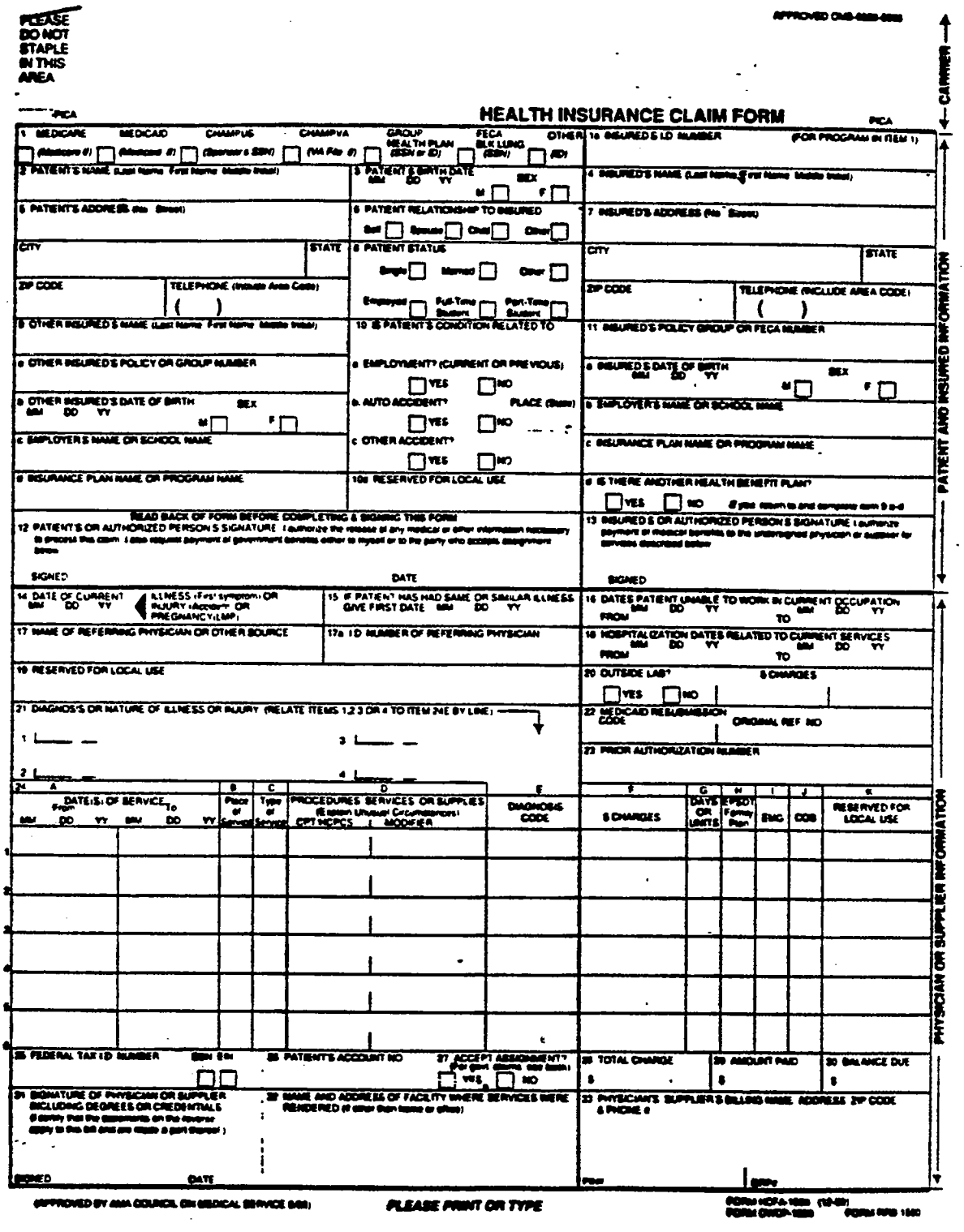
Block 30. Signature of Physician or Supplier

All Adjustment/Void forme must be signed.

Block 31. Physician or Supplier's Name, Address, Zip Code and Telephone

Enter requested information and the Provider Number of the individual (or group if billing for a group)

Block 32. Your Patient's Account Number



PLEASE DO NOT STAPLE IN THIS AREA

PCA

HEALTH INSURANCE CLAIM FORM

PCA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER 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

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

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a I.D. NUMBER OF REFERRING PHYSICIAN

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 RESERVED FOR LOCAL USE

20 OUTSIDE LAB? YES NO $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1 3

2 4

22 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25 FEDERAL TAX I.D. NUMBER SSN EIN

26 PATIENT'S ACCOUNT NO.

27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28 TOTAL CHARGE $

29 AMOUNT PAID $

30 BALANCE DUE $

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

MAIL TO:
LIBERTY
P.O. BOX 91030
BATON ROUGE, LA 70821
(800) 737-9947
924-5040 (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

ADJ. ☐ VOID ☐

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) | PATIENT'S DATE OF BIRTH | INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) | PATIENT'S SEX: MALE ☐ FEMALE ☐ | INSURED'S I.D., MEDICARE, AND/OR MEDICAID NO. (INCLUDE ANY LETTER)

TELEPHONE NO. | PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER | INSURED'S GROUP NO. (OR GROUP NAME)

OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER | WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. AN AUTO ACCIDENT? YES ☐ NO ☐ | INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | DATE FIRST CONSULTED YOU FOR THIS CONDITION | HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐

DATE PATIENT ABLE TO RETURN TO WORK | DATES OF TOTAL DISABILITY FROM THROUGH | DATES OF PARTIAL DISABILITY FROM THROUGH

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G. PUBLIC HEALTH AGENCY) | FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) | WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES ☐ NO ☐ CHARGES

DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, OR OR CODE
1
2
3

EPSDT REFERRAL YES ☐ NO ☐

ATTENDING PHYSICIAN (NAME AND MEDICAID NO.)

A. DATE OF SERVICE	B. PLACE OF SERVICE	C. RALY (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE CODE	D. DIAGNOSIS CODE	E. CHARGES	F. UNITS	G. T.O.S.	H.

CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

DATE OF REMITTANCE ADVICE WHAT LISTED CLAIM WAS PAID

REASONS FOR ADJUSTMENT

- ☐ 01 THIRD PARTY LIABILITY RECOVERY
- ☐ 02 PROVIDER CORRECTIONS
- ☐ 08 FISCAL AGENT ERROR
- ☐ 90 STATE OFFICE USE ONLY - RECOVERY
- ☐ 99 OTHER - PLEASE EXPLAIN

ADJUSTMENT

REASONS FOR VOID

- ☐ 10 CLAIM PAID FOR WRONG RECIPIENT
- ☐ 11 CLAIM PAID TO WRONG PROVIDER
- ☐ 99 OTHER - PLEASE EXPLAIN

SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE

YOUR PATIENT'S ACCOUNT NUMBER

BHSF Form PCA 4
Issued 7/1/92

STAFFING ATTENDANCE RECORD

Name _____ Period Covering _____ to _____

Date of Staffing _____ Purpose _____

Signatures of Participants:

_____, Client _____, Case Manager
_____,
_____,

Date of Staffing _____ Purpose _____

Signatures of Participants:

_____, Client _____, Case Manager
_____, MSW _____,
_____, _____,

Date of Staffing _____ Purpose _____

Signatures of Participants:

_____, Client _____, Case Manager
_____, _____,
_____, _____,

Date of Staffing _____ Purpose _____

Signatures of Participants:

_____, Client _____, Case Manager
_____, _____,
_____, _____,

Date of Staffing _____ Purpose _____

Signatures of Participants:

_____, Client _____, Case Manager
_____, _____,
_____, _____,

Date of Staffing _____ Purpose _____

Signatures of Participants:

_____, Client _____, Case Manager
_____, _____,
_____, _____,

BHSF Form PCA 4 PCA 4-1
Issued 7/1/92

STAFFING ATTENDANCE RECORD

Purpose:

Form PCA 4 is used by Personal Care Attendant Waiver providers to document attendance at a Title XIX applicant or recipient staffing.

Preparation:

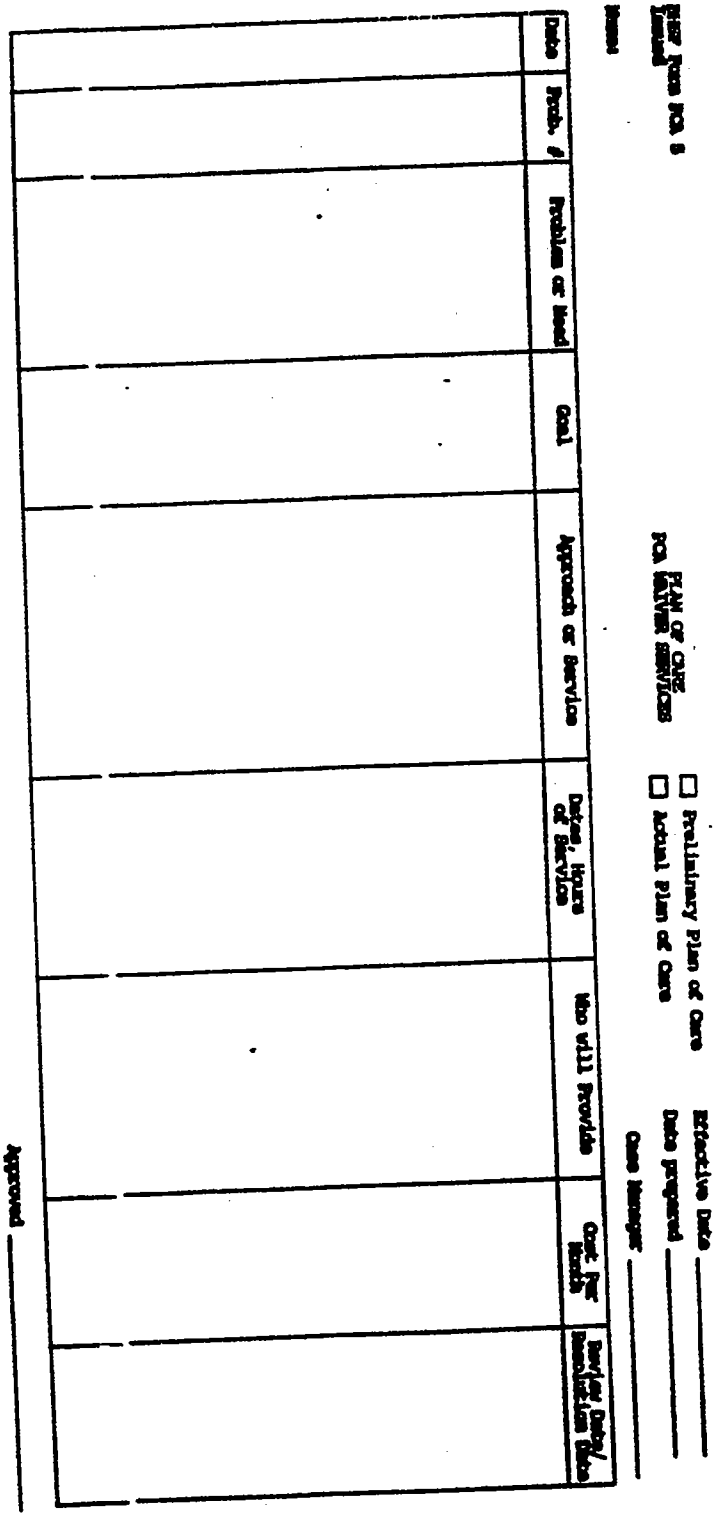
The name of the applicant or recipient is entered on the first line. The date of the first staffing documented on the form is entered after "period covering". The date of the last staffing documented on the form is entered after "to".

At each staffing, a section including date, purpose, and persons in attendance is completed. Each person in attendance shall enter his or her name and professional designation or purpose at the staffing.

Disposition:

The original of Form PCA 4 is retained in each recipient's record located at the provider site for at least three years following the end of each waiver period and is made available to state or federal staff upon request.

A copy of Form PCA 4 is submitted with other required data to the Health Standards Regional Office when determination of level of care and/or approval of plan of care is requested.


PLAN OF CARE
PCA WAIVER SERVICES
Preliminary Plan of Care
Actual Plan of Care
Effective Date
Date prepared
Case Manager
Approved
Date
Prob. #
Problem or Need
Goal
Approach or Service
Dates, Hours of Service
Who Will Provide
Cost Per Month
Review Date/ Resolution Date

PCA WAIVER PRE-APPLICATION

Applicant's Name: _____ Date: _____

Medicaid Number: _____ Staff: _____

I. Assistance required for activities of daily living (45 points max.):
(Add all numbers assigned below)
1.Minimal to none 2.Some Assistance 3.Total Care Assistance

__Ambulation	__Transfers	__Administering Medication
__Bathing	__Bowel	__Consumption of Food
__Grooming	__Bladder	__Written Communication
__Dressing	__Meal Preparation	__Verbal Communication
__Shopping	__Housekeeping	__Transportation

II. Support (non financial) (maximum of 45 points):

No One To Help With Primary Needs	Has Assistance But Not Enough To Meet All Primary Needs	Primary & Secondary Needs Are Met By Family Member Whose Health is Seriously Endangered	Primary Needs Are Met But Not All Secondary Needs Are Met
45	36	27	18

III. Financial (maximum of 10 points):

Gross monthly income of applicant _____
+ Gross monthly income of others _____ = _____
- $200 for each legally related person in household = _____
TOTAL: = _____

0-$800	$801-1266	$1267-1600	$1601-2000	$2001-2300	$2301-over
10	8	6	4	2	0

TOTALS FROM ABOVE:

Assistance required	(max. 45)	_____
Support non-financial	(max. 45)	_____
Financial resources	(max. 10)	_____
TOTAL		_____

CONCLUSION:

Institu. minent	High Risk for Institu.	Moderate Risk for Institu.	Low Risk for Institu.
90 - 75	74 - 69	68 - 51	50 - under

Forms

Explanation Sheet for PCA Waiver Pre-Application

I. Assistance required for activities of daily living

1. Ambulation: If the person uses a power wheelchair or can push their own manual wheelchair, they need minimal to no assistance with ambulation (1).

2. Bladder: If the person requires intermittant catheterization (ie: requiring assistance every four to eight hours to catheterize) or has an external catheter but requires assistance to empty bag, they need total care (3). If they have external catheter and can empty their own bag (ie: only need once a day to change catheter and bag) they need some assistance (2).

3. Administering Medication: If the person can take the medication on their own once someone sets it out, they need some assistance (2). If the person needs someone to administer medication and they require medication throughout the day, they need total care assistance (3).

II. Support non-financial

The secondary needs are: shopping, housekeeping, written communication, verbal communication and transportation. The primary needs are all others listed.

Existing assistance can be by family members, friends, home health care, respite or any other source of personal care assistance. The relevant factors are, not how many times they have assistance or the source of the assistance, but the level of assistance available relative to their needs. They might only have someone come once a week, but they might not need assistance with primary needs, and might only need someone twice a week to meet their secondary needs. They would get a twenty-seven (27).

The person might live with a family member who provides some daily assistance, but due to health factors or work, the family member is unable to meet their primary needs such as assisting with daily bowel or bladder care, transfers or ambulation. This situation would get a thirty-six (36).

If all primary and secondary needs are met, they would get zero (0).

III. Financial

Financial figures should be monthly gross income. We are determining ranking for priority, not eligibility for the waiver (which is three times the SSI amount, or $1266 per month).

1. Gross monthly income of person includes Salary, SSI, SSDI, Insurance payments, Public Assistance such as food stamps or AFDC, settlements, trust funds, etc.

2. Gross monthly income of others residing with them includes the same as above for family members or others contributing to their financial support.

4. Deduct $200 per month from the total for each legally related spouse, child or parent residing with the person who is also supported by the above income. Plug the total figure into (3) Financial.

La. OPS Form 148
Revised 11/89
IV
Prior Issues Obsolete

TITLE XIX LONG TERM CARE FACILITY
NOTIFICATION OF ADMISSION OR CHANGE

Date of Admission_____

Source of Admission ☐ Residence ☐ Hospital _____

☐ LTC Facility _____

From _____ Parish

Admission

Name of Facility_____ Provider No._____

Patient's Name_____ Birthdate_____ Race_____ Sex_____

Name of Spouse_____ Patient's Home Address_____

_____ Is patient a Medicaid recipient? ☐ Yes ☐ No

If yes, from what parish_____ OPS Case No._____

If not a Medicaid recipient, does patient wish to apply? ☐ Yes ☐ No

Name, Address and Phone No. of responsible person_____

Patient's personal funds handled by ☐ Patient ☐ Facility ☐ Other - Name, Address, and Phone No._____

Patient's Attending Physician Facility_____

Form 90L sent to LTC? ☐ Yes ☐ No Level of Care: Skilled___ ICFI ___ ICFII ___ICF/MR___MR____

☐ Referred for Level 2 Screening

Medicaid No. _____ Medicare No._____ Medicare Claimed ☐ Yes ☐ No

Patient on VA Contract? ☐ Yes ☐ No If yes, date contract will expire?_____

Date of Title XIX application (if later than admission) _____

☐ Medicare Referral

☐ Medicare Approved From_____ Through_____ ☐ Medicare Denied

Change in Recipient's Status

1. Discharged _____ (Date) To _____ (New Address)
2. On Leave But Not Discharged; Title XIX Billing Discontinued _____ as leave days exhausted
3. Readmitted_____ (Date) after hospitalization or home leave and leave days had been exhausted but patient not discharged.
4. Died on _____ (Date)
5. Transfer to Medicare Status _____ (Date)
6. Other:_____

_____ Date

_____ Signature of Facility Administrator or Authorized Representative

Chapter V 148-1

TITLE XIX LONG TERM CARE FACILITY: NOTIFICATION OF ADMISSION OR CHANGE

Form 148

Purpose

Form 148 shall be used by long term care facilities to notify the parish office and Long Term Care Unit Regional Office of admission or to report a change in a patient's status. Its use is mandatory as the initial step in securing medical certification for type care. It shall also be used to notify the local office within 24 hours of a change in a patient's status. Form 148 shall be initiated by the long term care facility at the time of admission of a medical assistance recipient or for a nonrecipient, at any time an application for medical assistance is requested, or when there is Rev.* a change in a recipient's status. Form 148 shall also be initiated by the facility when the recipient has exhausted his days of leave from the facility (either hospital or home leave) and the facility ceases billing Title XIX for vendor payments but the patient is not discharged. It shall also be used to report readmission following hospitalization or home leave ** of a patient whose leave days have been exhausted but who has not been discharged.

Preparation

Form 148 is completed by the facility administrator or his authorized representative. The necessary information for completion of the initial form should be secured from the patient or the person responsible for his admission. The information reporting a change in the patient's status should be that reflected in his medical record.

Disposition

Form 148 shall be sent to the parish office and Long Term Care Regional Office in single copy. The facility may retain a carbon copy for their files.

Any information on Form 148 which conflicts with information available from other sources shall be cleared. Information which is found to be incorrect on the Form 148 need not be changed, but case recording shall clearly show the correct information.

Form 148 shall be filed in the parish office case record and Long Term Care Unit Regional Office file.

Released January 1, 1979
Replacing March 1, 1977 issue

Form 148-HCB
Issued 10/83
IV

LOUISIANA OFFICE OF FAMILY SECURITY
TITLE XIX HOME & COMMUNITY BASED SERVICES
NOTIFICATION OF PARTICIPATION OR CHANGE

Date of First HCB Service: _____
Medicaid ID #: _____
Date of Title XIX Application: _____
Name of Provider _____ Provider No. _____
Participant's Name _____ Date of Birth: _____ Sex _____
Name of Spouse/Parent: _____
Home Address: _____
Does participant receive Social Security Disability Benefits: ☐ Yes ☐ No
Social Security Claim No. _____ Medicare No. _____
Is participant an SSI recipient: ☐ Yes ☐ No
If yes, OFS ID No. _____
Name, Address and Phone No. of responsible person _____
_____
Participant's Attending Physician or Treatment Facility: _____
Form 90-L sent to State Office Admission Review Unit: ☐ Yes No ☐
Level of LTC Care otherwise required: Skilled ____ ICF ____ ICF-II ____ ICF/E ____

Change in Recipient's Status

1. Service(s) discontinued effective _____ (Date)
   Reason: ☐ Died ☐ Placement in LTC Facility ☐ Other-Specify: _____
   ☐ Transfer to another HCB facility in same month
   Specify # days participated _____
2. Recipient not participating in accordance with service plan _____ (Date)
   Specify change(s) from service plan: _____
   _____
   Reason for change(s): _____
   _____
   _____

_____ (Date)

_____ Signature of Provider Administrator or Authorized Representative

Chapter V 148-HCB-1

TITLE XIX HOME & COMMUNITY BASED SERVICES
NOTIFICATION OF PARTICIPATION OR CHANGE
Form 148-HCB

Purpose

Form 148-HCB shall be initiated by providers of Home and Community-based services in the following instances:

(1) Notification of recipient's initial participation in HCB service to parish office; or

(2) Notification of a non-recipient's request to apply for medical assistance; or

(3) Notification of a change in recipient's status to the parish office and Regional Office LTC Unit; or

(4) Notification within ten days from the last date of service that the recipient is no longer participating or is not participating according to the service plan, to the parish office and Regional Office LTC Unit.

The information reporting a change in the recipient's status or participation should be reflected in the provider's record for recipient.

Preparation

Form 148-HCB is completed in triplicate by the provider or his authorized representative. The information necessary for completion of the initial form should be secured from the recipient or person responsible for his case.

Disposition

For notification of initial participation, a copy of Form 148-HCB shall be submitted to the parish office.

For notification of changes in recipient's status or participation, a copy shall be submitted to the parish office and the Regional Office LTC Unit. No action shall be taken by parish office when 148-HCB is submitted to report change in service plan.

The provider shall retain a copy for his files.

Any information on Form 148-HCB which conflicts with information available from other sources shall be cleared by the parish office. Information on Form 148-HCB which is found to be incorrect shall not be changed, but case recordings shall clearly show the correct information.

Upon receipt from provider, Form 148-HCB shall be filed in the parish office case record and Regional Office LTC Unit's file.

Issued October 1, 1983

CLIENT ELIGIBILITY PROCEDURE FOR PCA WAIVER SERVICES

July 1, 1992

PROVIDER	HEALTH STANDARDS RO	ELIGIBILITY WORKER	CLIENT
Stage 1 – Preparatory Phase			
meet w/ client, representative			meet w/ provider
complete 50–M			complete 50–M w/ provider
complete LTC/CS (optional)			
secure evaluations (90–L and others)			
meet w/ ID team			meet w/ID team
develop POC (HCBS 4 & 5)			
Stage 2 – Make Application (simultaneously)			
submit 148, LTC/CS and 50–M to PO		receive 148, LTC/CS and 50–M from provider	make application for finan. elig.
*if ind. not SSI elig. – also send 90–L		if no LTC/CS have client complete	(may include interview)
		*if indiv. not SSI elig.:	
		1. also receive 90–L	
		2. open 51–F with date of 50–M sig. unless earlier request is documented	
		3. schedule interview with family or client	
		4. submit 90 to MSRT for disability decision	
submit medical to RO	receive medical from provider		
90–L	90–L		
148	148		
Social or other Eval.	Social or other Eval.		
HCBS 4 & 5	HCBS 5		
Stage 3 – Medical Determination			
	determine med. elig. for NF		
	review medical for POC		
	notify of med elig (142)		
receive med. elig. (142)	provider		
	client		receive med. elig. (142)
	eligibility worker	receive medical elig. (142)	
	copy to pending files		
Stage 4 – Financial Eligibility			
		compute financial eligibility and PLI using 3–HCB (and 3–HCB(A) if child)	
		notify of finan. elig.& PLI(18–HCB)	
	receive not. of fin. elig.18HCB	BHSF RO	
		client	
receive not. of fin. elig.18HCB		provider	receive not. of fin. elig.18HCB
		case record	
Stage 5 – POC approval			
	determines adequacy of POC		
	notifies POC approved (51–NH)		
receive POC approval (51–NH)	provider		

CLIENT CERTIFICATION IS COMPLETE

MANUAL UPDATES

It is very important to read all the following documentation, as it contains information in addition to that found in the PCA Waiver Services Manual issued July 1, 1992.

Please note that the following pages were issued after the printing of the manual.

The information in the 1998 Basic Medicaid Provider Training packet, Medicaid Issues for 1998, was published in September, 1998.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

July 31, 1995

Edwin W. Edwards
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Rose V. Forrest
SECRETARY

TO: Case Management Agencies for Elderly Waiver Program
MR/DD Case Management Agencies
Personal Care Attendant Waiver Providers
Personal Care Attendant Service Providers
Respite Service Providers
Substitute Family Care Service Providers
Supervised Independent Living Service Providers
Supported Employment Service Providers
Day Habilitation Service Providers
Pre-vocational Habilitation Service Providers

FROM: Thomas D. Collins, Acting Director

RE: Instructions for Implementation of Emergency Rules

Emergency Rules were published effective July 7, 1995 and July 13, 1995 outlining cost-saving measures necessary to meet Fiscal Year 95/96 budgetary constraints. The following instructions are provided concerning the methods to be used in making the various changes.

The instructions are organized by service. Note that the instructions to case managers will be of interest to all service providers. No changes have been made to Personal Emergency Response Systems, Environmental Modifications, or Assistive Devices.

Many providers may have billed in the interim, using obsolete coding. Please adjust paid claims to conform with the correct coding as listed in the attached documentation. Claims which denied must be resubmitted, unless your agency has already made other arrangements with UNISYS.

Further notification will be made of any additions or amendments to these instructions as final decisions are made.

CHANGES TO HOME AND COMMUNITY BASED WAIVER SERVICES

MR/DD Waiver eligibility

1. Slots that become vacant in this waiver will not be filled until further notice.

2. Persons who have been allocated a slot, but have not been determined eligible must submit a financial eligibility application to the appropriate financial eligibility office before July 13, 1995. Applications for waiver slots will not be accepted on or after July 13, 1995.

3. Applications not processed within financial eligibility timeframes will be rejected when the timeframe expires.

4. The following activities must be accomplished prior to the end of the financial eligibility timeframe to establish eligibility:

   a) preparation of the plan of care
   b) obtaining medical, social, and psychological evaluations
   c) submission of packet to Health Standards
   d) issuance of Form 142 by Health Standards
   e) disability determination (when required)
   f) determination of financial eligibility, including all required documentation

5. Providers are reminded again that reimbursement for waiver services is available only for persons who have been determined eligible for the waiver, and that only services that are included in that waiver are covered. The waiver participant's case manager receives a Form 51-NH as notification that the applicant has been approved for a waiver slot. If in doubt, confirm with his/her case manager that the person requesting services is eligible for a waiver slot. Payments made for services provided to persons who are not eligible will be recovered from the agency that received payment for the service.

   Note: **Respite, Substitute Family Care, Supervised Independent Living, Prevocational Habilitation, and Day Habilitation services are available only to participants in the MR/DD waiver.**

   PCA is available only to participants in the MR/DD waiver, the PCA waiver, or the Home Care for the Elderly waiver.

   Personal Emergency Response Systems and Environmental Modifications are available only to participants in the MR/DD waiver or Home Care for the Elderly waiver.

   Assistive Devices are available only to participants in the MR/DD waiver.

   Case Management for the Elderly is available only to participants in Home Care for the Elderly waiver.

Notice to All Waiver Service Providers

Effective September 1, 1995, the case management agency's Medicaid Provider Number must be entered in Item 17a of the HCFA 1500 claim form submitted for all waiver services. Omission of the seven digit Medicaid Provider Number in Item 17a will result in the denial of the claim.

Case Management Agency Responsibilities

Agencies providing case management functions for waiver participants (MR/DD waiver, Home Care for the Elderly waiver, and PCA waiver) shall immediately amend plans of care. MR/DD and Elderly case managers shall issue replacement MR/DD 14's for services affected by the changes. Failure to timely amend plans of care shall be considered basis for findings during Utilization Review and any other record reviews performed after July 13, 1995.

The following changes to plans of care and MR/DD 14's shall be made immediately for services effective July 13, 1995. The ID team is to be reconvened as necessary to make the following changes. The MR/DD 14 shall specify which services are removed by procedure code, and which are decreased or otherwise changed, also by procedure code.

PCA

1) Change units to half-hour, correct number.
2) Remove PCA for participants while in Supervised Independent Living setting.
3) Remove PCA for children under age 5.
4) Remove PCA over 400 half-hour units per month.
5) Remove PCA over 3,650 half-hour units per calendar year beginning January 1, 1995.
6) Change procedure code for each recipient whose care is provided by a PCA who is simultaneously caring for more than one waiver participant in the same home.
7) Change procedure code for each recipient whose care is provided by more than one PCA.
8) Notify providers via MR/DD 14.

Respite

1) Change units to half-hour, correct number.
2) Adjust respite hours as necessary to remain within 720 half-hour units from July 13, 1995 through December 31, 1995, and 1,440 half-hour units per calendar year beginning January 1, 1995.
3) Change procedure code for each recipient whose care is provided by a respite worker who is simultaneously caring for more than one waiver participant in the same home.
4) Change procedure code for each recipient whose care is provided by more than one respite worker at the same time.
5) Notify providers via MR/DD 14.

Residential Habilitation/Supervised Independent Living

1) Remove PCA for participants while in Supervised Independent Living setting.
2) Remove SIL Training, Consultation, and Companion services.
3) Review SIL plan of care to determine number of hours of staff time necessary to carry out plan for 30 days. Divide by number of days in the month to determine number of hours per day necessary to carry out the provider plan of care. Look up the appropriate SIL procedure code based on number of hours of staff care required and number of waiver participants in the household.
4) Notify providers via MR/DD 14.

Supported Employment

1) Remove Individual Job/Intense Training from plans of care.
2) Notify provider via MR/DD 14.

Other Waiver Services

No changes to plan of care or MR/DD 14 are required.

Personal Care Attendant (PCA) Agencies

Note: Payment for PCA services is available using these codes only for persons who have been determined eligible for the MR/DD waiver, Home Care for the Elderly waiver, and PCA waiver. Procedures and codes for PCA as a Kid-Med service are not included in this section.

The following changes are effective July 13, 1995:

1. Billing shall be in half-hour units. A full half-hour of service shall be provided in order to bill for the service. Minutes from different occasions of service provision shall not be rolled together to accumulate half-hour units.

2. PCA services shall not be payable separately for waiver participants in Supervised Independent Living (SIL). Reimbursement for SIL will be a daily rate which includes PCA, companion, consultation, and training.

3. PCA shall not be available for children under the age of 5, as all young children require assistance with daily care needs. A child must have reached his/her fifth birthday for PCA claims to pay.

4. Reimbursement for services shall be limited to 200 hours (400 half-hours) per calendar month.

5. Annual service limit shall be 1,825 hours (3,650 half-hour units) per calendar year, with no exceptions.

6. The reimbursement rate for PCA provided as a waiver service shall be $5.00 per half-hour unit, except as provided below for care given to multiple participants by the same attendant or care by multiple workers to one or more participants.

7. The reimbursement rate for PCA provided to more than one waiver participant in the same home by a single attendant shall be 75% of the reimbursement rate for PCA provided to one waiver participant ($3.75 per half-hour).

8. The reimbursement rate for PCA provided to one or more waiver participants in the same home by two attendants shall be 75% of the reimbursement rate for PCA services (for each attendant) provided to one waiver participant by one attendant ($7.50 per half-hour).

Procedure codes for PCA services are as follows:

Proc.Code	Description	Rate	Unit Size	Maximum Units
Z0002	**MR/DD waiver** Personal Care Attendant for individual	$5.00	half-hour	**combined total:** 400 units/month and 3,650 units/year and 1,825 units from July 13, 1995 through December 31, 1995
Z0067	**MR/DD waiver** Personal Care Attendant for multiple clients	$3.75	half-hour	
Z0085	**MR/DD waiver** Personal Care Attendant with multiple staff	$7.50	half-hour	
Z0057	**Home Care for the Elderly waiver** Personal Care Attendant for individual	$5.00	half-hour	
Z0068	**Home Care for the Elderly waiver** Personal Care Attendant for multiple clients	$3.75	half-hour	
Z0086	**Home Care for the Elderly waiver** Personal Care Attendant with multiple staff	$7.50	half-hour	
Z0010	**PCA waiver*** Personal Care Attendant for individual	$5.00	half-hour	
Z0069	**PCA waiver*** Personal Care Attendant for multiple	$3.75	half-hour	
Z0087	**PCA waiver*** Personal Care Attendant with multiple staff	$7.50	half-hour	

Note: *Services under the PCA waiver are to be billed only by the 3 enrolled Independent Living Centers.

Procedure code Z0011 is no longer payable for dates of service beginning July 13, 1995.

Respite Agencies

Note: Payment for respite services is available through Medicaid only for persons who have been determined eligible for the MR/DD waiver.

The following changes are being made to Respite services effective July 13, 1995.

1. Billing shall be in half-hour units. A full half-hour shall be provided in order to bill for the service. Minutes from different occasions of service provision shall not be rolled to accumulate half-hour units.

2. The reimbursement rate for in-home Respite shall be $5.00 per half-hour unit, except as provided below for care given to multiple participants by the same respite worker or care by multiple workers to one or more participants.

3. The reimbursement rate for in-home respite provided to more than one waiver participant in the same home by a single attendant shall be 75% of the reimbursement rate for respite provided to one waiver participant ($3.75 per half-hour).

4. The reimbursement rate for in-home Respite provided to one or more waiver participants in the same home by two Respite workers shall be 75% of the reimbursement rate (for each attendant) for Respite services provided to one waiver participant by one Respite worker ($7.50 per half-hour).

5. The reimbursement rate for center-based Respite shall be $5.00 per half-hour unit for Respite services provided to one waiver participant by one Respite worker. Medical necessity must be documented in the plan of care when the needs of the waiver participant require the full-time attention of a Respite worker.

6. The reimbursement rate for center-based respite provided to more than one waiver participant at the same time by a single attendant shall be 75% of the reimbursement rate for respite provided to one waiver participant ($3.75 per half-hour).

7. Annual service limit shall be 720 hours (1,440 half-hour units) per calendar year, with no exceptions. A service limit of 360 hours (720 half-hour units) will be applicable for services provided from July 13, 1995 through December 31, 1995. Thereafter, a calendar year service limit of 1440 half-hour units will be applicable.

Procedure codes for Respite services are as follows:

Proc. Code	Description	Rate	Unit Size	Maximum Units
Z0003	**MR/DD waiver** In-home Respite for Individual	$5.00	half-hour	**combined total:** 1,440 units/year and 720 units from July 13, 1995 through December 31, 1995
Z0075	**MR/DD waiver** In-home Respite for multiple clients	$3.75	half-hour	
Z0084	**MR/DD waiver** In-home Respite with multiple staff	$7.50	half-hour	
Z0004	**MR/DD waiver** Center-based Respite shared attendant	$3.75	half-hour	
Z0014	**MR/DD waiver** Center-based Respite individual attendant	$5.00	half-hour	

Procedure Code Z0013 is not payable for dates of service beginning July 13, 1995.

Supervised Independent Living Agencies

Note: Payment for Supervised Independent Living services is available through Medicaid only for persons who have been determined eligible for the MR/DD waiver.

The following changes are being made to Supervised Independent Living services effective July 7, 1995:

1. Separate reimbursement for consultation, PCA, extended training, and companion services will no longer be allowed.

2. Residential Habilitation/Supervised Independent Living providers shall be required to be licensed as both Supervised Independent Living and Personal Care Attendant agencies by Department of Social Services, Bureau of Licensing.

3. Services may be billed only for days in which the waiver participant is present in the residential habilitation setting. Services may not be billed for days when the client is absent from the home. The participant will be considered absent from the home when the participant is absent from the residential habilitation setting for a continuous 24 hour period, and the provider shall not bill for the day.

   Example: A SIL client who leaves the home on Friday evening at 6:00 p.m. and returns Sunday morning at 9:00 a.m. has been gone for 39 hours (one 24-hour period). Do not bill for Saturday.

   Example: A SIL client who leaves the home on Friday evening at 6:00 p.m. and returns Sunday evening at 6:00 p.m. has been gone for 48 hours (two 24-hour periods). Do not bill for Saturday or Sunday.

4. Span dating will continue to be accepted for processing. However, claims must be split billed when there is a break in service(non-payable day).

5. Reimbursement shall consist of flat daily rates for participants in single-participant households, 2-participant households, and 3-participant households who require less than three hours daily of direct-care staff time, 3 to 10 hours daily of direct-care staff time, and 10 or more hours daily of direct-care staff time. Direct-care staff time includes actual time spent providing personal care services, training, and companion services. Base rate includes administrative costs and all direct-care staff time for persons requiring up to an average of three hours of care per day. Total required hours of care for the month are to be divided by the number of days in the month to arrive at the average of hours per day of direct-care staff time required.

   Note: The rate for 2-person and 3-person households is applicable for all waiver participants residing in the household. DO NOT bill single-person rate for one resident and multiple-person rates for other residents.

Case management agencies shall calculate the correct number of hours of direct-staff care from the current provider plan of care and issue new forms MR/DD 14 effective July 13, 1995. Participants currently receiving base rate with no PCA, companion, or extended training shall continue to receive base rate. Participants receiving PCA, companion, or extended training shall continue to receive the same amount of service per the provider plan(s) of care. **All MR/DD 14's for Supervised Independent Living are obsolete as of July 13, 1995.**

Procedure codes for Supervised Independent Living services are as follows:

Single participant in household		
$20.00	Z0006	base rate - up to average 3 housr/day
$53.69	Z0076	intermittent care - 3 to 10 hours/day
$108.13	Z0077	substantial care - 10 or more hours/day
Participant in 2-participant household		
$20.00	Z0078	base rate - up to average 3 hour/day
$40.21	Z0079	intermittent care - 3 to 10 hours/day
$72.88	Z0080	substantial care - 10 or more hours/day
Participant in 3-participant household		
$20.00	Z0081	base rate - up to average 3 hour/day
$30.11	Z0082	intermittent care - 3 to 10 hours/day
$55.25	Z0083	substantial care - 10 or more hours/day

Procedure codes Z0015, Z0016, Z0053, Z0054, and Z0055 are not payable for dates of service beginning July 1, 1995.

Supported Employment

Note: Payment for Supported Employment services is available through Medicaid only for persons who have been determined eligible for the MR/DD waiver.

The following changes are being made to Supported Employment services effective July 7, 1995:

1. Reimbursement for Individual Job/Intense Training (levels 1-4) will no longer be provided.

2. Reimbursement shall be at reduced by 10% of the current rates.

The following rates are effective for services provided July 7, 1995 or later:

Rate	Proc. Code	Description
$24.91	Z0021	Individual Job/Follow-along 30+ hours Level 1
$26.87	Z0022	Individual Job/Follow-along 30+ hours Level 2
$30.14	Z0023	Individual Job/Follow-along 30+ hours Level 3
$36.68	Z0024	Individual Job/Follow-along 30+ hours Level 4
$22.95	Z0025	Individual Job/Follow-along 20-30 hours Level 1
$24.42	Z0026	Individual Job/Follow-along 20-30 hours Level 2
$26.87	Z0027	Individual Job/Follow-along 20-30 hours Level 3
$31.77	Z0028	Individual Job/Follow-along 20-30 hours Level 4
$26.88	Z0029	Enclave/Mobile Crew Level 1
$32.76	Z0030	Enclave/Mobile Crew Level 2
$36.68	Z0031	Enclave/Mobile Crew Level 3
$43.41	Z0032	Enclave/Mobile Crew Level 4

Procedure codes Z0017, Z0018, Z0019, and Z0020 are not payable for dates of service beginning July 7, 1995.

Prevocational Habilitation

Note: Payment for Prevocational Habilitation services is available through Medicaid only for persons who have been determined eligible for the MR/DD waiver.

The following change is being made to Prevocational Habilitation services effective July 7, 1995:

Reimbursement shall be reduced by 10% of the current rates.

The following rates are effective for services provided July 7, 1995 or later:

$21.83	Z0033	Prevocational Habilitation Level 1
$24.21	Z0034	Prevocational Habilitation Level 2
$26.58	Z0035	Prevocational Habilitation Level 3
$36.09	Z0036	Prevocational Habilitation Level 4

Day Habilitation

Note: Payment for Day Habilitation services is available through Medicaid only for persons who have been determined eligible for the MR/DD waiver.

The following change is being made to Day Habilitation services effective July 7, 1995:

Reimbursement shall be reduced by 10% of the current rates.

The following rates are effective for services provided July 7, 1995 or later:

$21.83	Z0037	Day Habilitation Level 1
$24.21	Z0038	Day Habilitation Level 2
$26.58	Z0039	Day Habilitation Level 3
$36.09	Z0040	Day Habilitation Level 4

Case Management for the Elderly

Note: Payment for Case Management for the Elderly is available through Medicaid only for persons who have been determined eligible for the Home Care for the Elderly waiver.

The following changes are being made to Case Management for the Elderly effective July 13, 1995.

1. Subsequent-month Case Management for the Elderly shall be reimbursed using a flat monthly rate to be billed for the second and subsequent months of waiver participation. The monthly rate will be $75.00 per month. A minimum of two hours of service coordination and/or monitoring of service providers must be provided in order to bill for services in a month. Procedure code Z0088 shall be used for Subsequent-month Case Management for the Elderly beginning July 13, 1995.

2. The rate for initial-month case management (Procedure Code Z0064) is reduced to $120.00 per month.

3. Procedure Code Z0064 shall be billed for the first month that the waiver participant is eligible (and shall be billed only once in a lifetime), and procedure code Z0088 for each subsequent month. Only one code will be paid each month.

Rate	Proc. Code	Description
$120/month	Z0064	Initial-month Case Management for the Elderly
$13.26/15 minutes	Z0065	Subsequent-month Case Management for the Elderly prior to July 13, 1995
$75/month	Z0088	Subsequent-month Case Management for the Elderly beginning July 13, 1995

Edwin W. Edwards
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Department of HEALTH and HOSPITALS
Rose V. Forrest
SECRETARY

October 30, 1995

TO: Case Management and Service Providers for the MRDD, PCA and Home Care for the Elderly Waiver Programs

FROM: Thomas D. Collins, Acting Director

RE: July 7, 1995 and July 13,1995 Emergency Rules for HCBS Waiver Programs repealed.

The Department of Health and Hospitals has determined that it is necessary to repeal the emergency rules of July 7, 1995 and July 13, 1995 on the Home and Community Based Waiver Programs. Emergency Rules were published effective October 10, 1995 to reinstate the regulations for the Waiver Programs that were existent prior to the July 1995 emergency rules.

~~The attached page outlines the procedure codes applicable for each HCBS Waiver. Note that the codes are the same as those used prior to the July changes.~~

All changes are effective for dates of service October 10, 1995. Claims billed for dates of service July 13, 1995 to October 9, 1995 will continue to be paid according to the Emergency Rules of July 1995. Claims denied due to obsolete coding must be resubmitted.

The case management agency's Medicaid Provider Number must be entered in Item 17a of the HCFA 1500 claim form submitted for all waiver services. Omission of the seven digit Medicaid Provider Number in Item 17a will result in the denial of the claim. This policy continues to be a requirement for the submission of waiver services claims.

If you have any questions regarding the information in this notice, you may contact Robert Babin at 504-342-3975.

THE FOLLOWING PAGE LISTS THE MOST CURRENT HCBS WAIVER PROCEDURE CODES.

HCBS WAIVERS

Effective Oct. 10, 1995

MRDD WAIVER

	Code	Description	Rate	unit size	Max / Yr
PCA					
	Z0002	PCA	$10.05	1 hour	comb
	Z0011	PCA HIGH NEED	$11.36	1 hour	1825 units
RESPITE					
	Z0003	In-HOME RESPITE	$10.05	1 hour	
	Z0013	In-HOME RESPITE HIGH NEED	$11.36	1 hour	no
	Z0004	CENTER-BASED RESPITE	$6.50	1 hour	limit
	Z0014	CENTER-BASED RESPITE HIGH NEED	$11.36	1 hour	
SUBSTITUTE FAMILY CARE					
	Z0005	Substitute Family Care	$11.17	day	1 unit/day
RESIDENTIAL HABILITATION					
	Z0006	SIL	$22.76	day	1 unit/day
	Z0015	SIL TRAINING	$10.70	hour	
	Z0016	SIL CONSULTATION	$45.00	hour	
	Z0053	SIL Companion (Day)	$6.00	hour	
	Z0054	SIL Companion (Behavior Modification)	$10.00	hour	
	Z0055	SIL Companion (Night)	$4.00	hour	
HABILITATION/SUPPORTED EMPLOYMENT					
	Z0017	Ind. Job/Intense training level 1	$36.40	day	
	Z0018	Ind. Job/Intense training level 2	$40.75	day	
	Z0019	Ind. Job/Intense training level 3	$48.23	day	
	Z0020	Ind. Job/Intense training level 4	$62.55	day	
	Z0021	Ind. Job/Follow-along 30+ hours Level 1	$27.68	day	
	Z0022	Ind. Job/Follow-along 30+ hours Level 2	$29.86	day	comb
	Z0023	Ind. Job/Follow-along 30+ hours Level 3	$33.49	day	276 units
	Z0024	Ind. Job/Follow-along 30+ hours Level 4	$40.75	day	
	Z0025	Ind. Job/Follow-along 20-30 hours Level 1	$25.50	day	
	Z0026	Ind. Job/Follow-along 20-30 hours Level 2	$27.13	day	
	Z0027	Ind. Job/Follow-along 20-30 hours Level 3	$29.85	day	
	Z0028	Ind. Job/Follow-along 20-30 hours Level 4	$35.30	day	
	Z0029	Enclave / Mobile Crew Level 1	$29.86	day	
	Z0030	Enclave / Mobile Crew Level 2	$36.40	day	
	Z0031	Enclave / Mobile Crew Level 3	$40.75	day	
	Z0032	Enclave / Mobile Crew Level 4	$48.23	day	
PRE-VOCATIONAL HABILITATION					
	Z0033	Pre-Vocational Habilitation Level 1	$24.25	day	
	Z0034	Pre-Vocational Habilitation Level 2	$26.89	day	comb
	Z0035	Pre-Vocational Habilitation Level 3	$29.53	day	276 units
	Z0036	Pre-Vocational Habilitation Level 4	$40.10	day	
DAY HABILITATION					
	Z0037	Day Habilitation Level 1	$24.25	day	
	Z0038	Day Habilitation Level 2	$26.89	day	comb
	Z0039	Day Habilitation Level 3	$29.53	day	276 units
	Z0040	Day Habilitation Level 4	$40.10	day	
PERSONAL EMERGENCY RESPONCE SYSTEM					
	Z0052	P.E.R. System - Installation	$30.00	each	1unit
	Z0045	P.E.R. System - Month	$27.00	month	12 units
ENVIRONMENTAL MODIFICATIONS					
	Z0041	Ramp		each	combo
	Z0042	Lift		each	Lifetime
	Z0043	Bathroom Modifications		each	limit
	Z0044	Adaptations		each	$3,000
ASSISTIVE DEVICES					
	Z0046	Adaptive aids - Lifts		each	
	Z0047	Adaptive aids - Switches		each	combo
	Z0048	Adaptive aids - Controls		each	Lifetime
	Z0049	Communication aids - Communicators		each	limit
	Z0050	Communication aids - Speech devices		each	$5,000
	Z0051	Communication aids - Interpreters		hour	

Effective April 1, 1997

ELDERLY/DISABLED ADULT WAIVER

CASE MANAGEMENT					
	Z0188	Case Management - initial hour	$49.50	1 hour	1 per mo
	Z1188	Case Management - additional units	$12.38	15 min	4 per mo
PCA					
	Z0070	PCA	$5.00	1/2 hour	
	Z0071	Household Supports	$4.00	1/2 hour	3650/YR
	Z0072	Personal Supervision (Day)	$3.00	1/2 hour	combo
	Z0073	Personal Supervision (Night)	$2.00	1/2 hour	
PERSONAL EMERGENCY RESPONSE SYSTEM					
	Z0058	P.E.R. system - installation	$30.00	each	once
	Z0059	P.E.R. system - month	$27.00	month	1 per mo
ENVIRONMENTAL MODIFICATIONS					
	Z0060	Ramp		each	combo
	Z0061	Lift		each	Lifetime
	Z0062	Bathroom Modifications		each	limit
	Z0063	Adaptations		each	$3,000

PCA WAIVER

PCA					
	Z0010	PCA	$10.05	1 hour	1825 units

ADULT DAY HEALTH

80% OF ICF/MR FACILITY PER DIEM RATES (ON AVERAGE $30 PER DAY)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

Bobby P. Jindal
SECRETARY

October 6, 1997

TO: All Case Management Providers, Service Providers and Consumers

From: Thomas D. Collins
Director

RE: Use of the New Comprehensive Care Plan Form(HCW-11) Revised 6/97

COMPREHENSIVE PLAN OF CARE

The Bureau of Health Services Financing has published and issued a new form on which you are now required to submit the Comprehensive Plan of Care (CPOC). The CPOC form is number HCW-11. Copies of the HCW-11 were given out at state wide training sessions conducted in June 1997. Additional copies of the HCW-11 can be obtained from Health Standards. The full HCW-11 is required for initial care plans, annual care plans and interim changes to the care plan that involve major changes to the types of service and number of services needed by the recipient to meet their daily needs. The annual CPOC must be approved before case managers authorize continuing services. Services authorized without Health Standards approval are subject to recovery.

The BHSF has also issued and trained on a shorter form (HCW-11R) to be used for minor and routine changes to the care plan. This shorter form can be also obtained from Health Standards.

The effective date for using the newly issued care plan forms was July 1, 1997. Care plans submitted on other forms or in other formats will be returned to the Case Management agency without action. Incomplete care plans will also be returned to the Case Management agency without action. Care should be taken to submit a full and complete packet on the proper forms to avoid delays in processing which cause delays in your client receiving needed services. If you have questions concerning the form or the instructions for use of the form please direct your inquiries to your Health Standards Regional Office.

Case managers may continue to issue Form 14 for services on the approved care plan. Changes to the CPOC including additions and deletions must be submitted to Health Standards for approval prior to issuing Form 14.

We have received many positive responses to the new form and we have found it to be helpful in

gathering and summarizing the necessary information to make accurate, consistent, justifiable and timely decisions. This new form was developed to prevent numerous requests from Health Standards to the Case management agencies for additional information. On this form all needed information is called for in the document being completed by the Case Management agency. There should be minimal need for requesting additional information if the document is complete and explicit when submitted.

BREAKS IN SERVICE

The agency has explored with HCFA the issue of the "14 day" rule. The eligibility for persons in the Waiver is based on policy for persons in institutions. This is in accordance with federal regulations. In order for the institutional policy of (1) Disregarding parental income for months after the first month of institutionalization and (2) A higher income eligibility limit, to apply to a person in an institution or in a waiver that person must be continuously institutionalized. In determining what the term "continuously institutionalized" means we have always used the SSI policy that terminates institutional status after 14 days.

We have now agreed with HCFA that a rule similar to the rule for determining the first full month of institutionalization will be used to determine non-institutional status. Therefore, the agency is publishing policy to provide for non-institutional status only after 30 days of being out of a facility or 30 days of non receipt of waiver services. This policy complies with the requirement that a person be in an institution or in the waiver for 30 full days before eligibility can be established. We believe this policy will allow more flexibility both for the institutionalized and waiver clients.

COMMUNICATION DEVICES

Please see the attached correspondence which was issued to address problems with obtaining approvals on communication devices. Please review this policy so that you may adhere to the process and speed the approval time.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

M. J. "Mike" Foster, Jr.
GOVERNOR

March 29, 1996

Department of HEALTH and HOSPITALS
Bobby P. Jindal
SECRETARY

M E M O R A N D U M

TO: CASE MANAGEMENT PROVIDERS

FROM: Thomas D. Collins
Acting Director

RE: Authorization of Communication Aids

Through review of provider claims and case management authorizations we have noted instances in which computer equipment has been authorized as communication aids. In the instances under review the communication aids authorized did not meet the Medicaid Medical Necessity criteria. We are issuing the following instructions to clarify your responsibilities with regard to authorizations of this and other type equipment.

For children under 21, communication aids and all other requests for Durable Medical Equipment must be made through the Medicaid Prior Authorization Unit in accordance with current procedures, case managers should no longer issue form 14 for children under 21.

For individuals over 21, communication aids shall be authorized by the case manager only as listed below.

1. There must be a recent (within 90 days) Augmentative Communication Screening and Assessment done by a licensed speech and language therapist.

2. The Screening and Assessment must provide documentation of the individual need for an aided communication system rather than an unaided one (sign language and gestures).

3. The Screening and Assessment must document the individual will be physically and mentally able to use the system (an occupational therapist can evaluate the motor abilities).

4. There must be documentation from the Speech and Language Therapist and from the provider as to the course of Training available to the client for use of the device and the schedule of training that has been recommended for the individual client.

In order to assist you in reaching decisions we are providing you with our Louisiana Assistive Technology Access Network (LATAN) regional office numbers. LATAN is part of the Citizens with Developmental Disabilities Council and has the expertise to offer consultation and guidance about communicative devices.

LATAN North
Johniece Whitehead, Advocacy Coordinator
P.O.Box 500
Sarepta, LA 71071
1-800-349-2774

LATAN Baton Rouge
Joyce Smith, Director
4573 Bennington Ave
Baton Rouge, LA 70808
1-800-269-8802

LATAN New Orleans
Joan Coussan, Director
4937 Hearst Plaza, Suite 21
Metairie, LA 70001
1-800-889-1647

Individuals who meet the criteria may have an augmentative device approved by you. Please remember when authorizing that there are LIFETIME limits which once exceeded are gone forever. The services authorized should be enduring.

Non-Billable Items - Computer equipment and software which does not meet this criteria and which is educational in nature are not covered by the waiver and should not be authorized by you.

There is a lifetime limit of $5,000 on this equipment and combining of adaptations with assistive devices for the purpose of circumventing the limit is prohibited. In instances when the communication device and an environmental modification perform a dual function of electronically assisting the individual with controlling the environment, the Medicaid Agency must be consulted for consideration of these dual function devices.

In our next notice to you we will give you guidance on environmental modifications. This is to remind you that your authorization of an environmental modification carries with it the same responsibility for prudence and objective decision making as do communicative devices. We will make available some of the ADA criteria for home improvements that need to be considered before someone builds a ramp, alters bath rooms etc.

If you have any questions regarding this clearance please contact Robert Babin, Specialist for waivers, at 504-342-9535. Case management questions should be addressed to Guy Kaufman, Specialist for case management, at 504-342-9768.

INSTRUCTIONS FOR THE COMPREHENSIVE PLAN OF CARE

INSTRUCTIONS FOR THE

COMPREHENSIVE PLAN OF CARE

Revised 10-97

GENERAL PURPOSE

The CPOC is designed to briefly summarize important information so that it can be quickly reviewed and considered in evaluating the need for proposed services and supports. Obviously, information critical to the client's health and safety or that of others should be more extensively documented in other materials. As there are four Waiver programs, the information requested may vary in relevance for a given individual.

The CPOC is intended to be user friendly, person specific, and flexible to varying approaches, orientations, and programs. The goal is to provide services and supports in a client focused, cost effective and accountable manner. The CPOC should always emphasize the client's personal goals and that of their family in order to maintain the waiver as a viable and appealing alternative to institutional care. **Only information relevant and applicable to justifying service requests for the applicant must be provided.**

CLIENT DEMOGRAPHICS:

This initial portion of the CPOC requires the ID Team to provide current information on the client, including name, address, medicaid/medicare number, guardian, and guardian address, and case management agency. Also, this section requests a description of the current and proposed living situation which will be different for some clients. Only relevant portions need to be completed.

I. CLIENT PROFILE

This section summarizes important aspects of client functioning and legal status. Additionally, medication needs, natural supports, client adaptive functioning and habilitation goals/needed supports are described. The specific components of the Client Profile are described below:

A. LEGAL STATUS:

This section documents the client's current legal status. This includes stating whether the client is interdicted, a ward of the state, or whether he or she has a legal guardian. Also, this section should document whether the client has pending legal charges or a history of incarceration.

B. HEALTH STATUS:

1.Physical Status: This section describes the client's functional limitations in vision, hearing, mobility, use of arms/hands, and need for assistive devices, as relevant.

2. Medical: This section describes the client's medical status, including all current medical diagnoses, description of all current health problems and needs. The information comes from the 90-L and other data documenting the client's health history and medical needs.

3. Psychiatric/Behavioral Concerns: This section requires a description of the client's psychiatric status, diagnoses, and significant behavior problems. Descriptions of client behavior problems should provide relevant information on situational variables that affect the occurrence of the behavior. Any relevant history regarding suicidal or homicidal ideation, intent, or attempt as well as history of elopement, aggression, and inappropriate sexual behavior should be provided. Also, information on effective behavioral interventions and skills training should be detailed in accompanying documentation.

C. MEDICATION/PROCEDURES:

This section lists all prescribed and over the counter medications, and/or medical procedures. Include medication dosage, route of administration, frequency of administration and individual or service provider responsible for administration. Include procedure descriptions (e.g., dressing changes, tube feeding, breathing treatment, enemas), procedure frequency, and person/agency responsible for performing the procedures. For example, state family member, personal care attendant, nurse, etc.

D. NATURAL SUPPORTS:

This section is intended to document and encourage the utilization of family and community supports. Of course, family and community supports may be limited depending on the individual. However, by law, medicaid services are to be provided after other sources of funding and support have been utilized and should be explored and encouraged. Utilization of non-medicaid services and supports can reduce duplication of service delivery.

E. ADAPTIVE BEHAVIOR FUNCTIONING:

This section provides very specific information of the client's current skills and functional impairments in various areas of adaptive functioning. This information is

taken directly from the psychological evaluation, social history, and from those individuals familiar with the client. Below are definitions of each area.

1. **Health and Safety**: Skills related to maintenance of one's health, basic safety considerations (e.g., using seat belts, crossing streets, interacting with strangers, etc.), and regular physical and dental check-ups. The client's ability to effectively respond to an emergency and self-evacuate must be documented.

2. **Self-Care**: Skills involved in toileting, eating, dressing, hygiene, and grooming.

3. **Home-Living**: Skills related to functioning within a home, which include clothing care, housekeeping, property maintenance, food preparation, planning and budgeting for shopping, home safety, and daily scheduling.

4. **Communication**: Skills include the ability to comprehend and express information through symbolic behaviors (e.g., spoken word, written word, sign language) or nonsymbolic behaviors (e.g., facial expression, body movement, touch, gesture). A specific statement indicating whether the client is primarily verbal or non-verbal should be included.

5. **Social Skills**: Skills in the social area are related to having interactions with others, developing and maintaining friendships and heterosexual relationships, recognizing and expressing feelings, regulating one's own behavior, and controlling impulses, as appropriate to various social situations.

6. **Community Use**: Skills related to the appropriate use of community resources, including grocery shopping, general shopping and ordering and eating in a restaurant, attending church or synagogue, using public transportation and public facilities.

7. **Leisure:** Leisure skills include the development of a variety of leisure and recreational interests that reflect personal preferences and choices.

8. **Vocational/Academic**: Vocational skills are related to holing a part or full-time job in the community in terms of specific job skills, appropriate social behavior, and related work skills. Managing money earned would also be included in this area. Academic skills include cognitive abilities and skills related

to learning at school that also have direct application in one's life. The focus is on academic skills that are functional in terms of independent living.

F. HABILITATION GOALS AND NEEDED SUPPORTS:

This section is used to describe training goals and supports needed for the client to function in the community. The client's goals and preferences should always be included in any decision making regarding training or needed supports. Training goals should be written in a way that changes in adaptive behavior can be measured and determined. There are some situations in which skills training is not relevant as the client is unlikely to ever learn to perform the skill such as a quadriplegic who is unlikely to walk. In these cases, the client would need support to complete the task. Needed supports should be written so that the amount and type of support given is clearly defined.

II. CPOC: SERVICE NEEDS

COLUMN 1: GOALS AND NEEDED SUPPORT:

This section utilizes information from all other sections to determine the goals or needs of the client, service areas and frequency of service delivery, and anticipated outcome. The Goal or Needed Supports section is taken directly from the Client Profile data (A-F). The suggested order for the requested services is: case management, medical needs, psychiatric / behavioral needs, habilitation goals and needed supports.

COLUMN 2: SERVICE AREA/FREQUENCY:

The service area specifies who will provide the service (as indicated by the letters A-R) for addressing the client's training goals, medical or behavioral needs, or other needed supports. It is important to list family, community, and non-medicaid sources of service provision whenever possible.

Included in this column is a description of the frequency of service delivery the provider will use to meet the client's need. For example, "assist with bathing once daily and hair washing three times weekly to be performed by family and the PCA."

COLUMN 3: ANTICIPATED OUTCOME:

The Anticipated Outcome section is used to outline the desired outcome of training or needed supports. This may reflect skill acquisition or may simply be a statement regarding the client's maintenance in the home and community with provided supports. For example, an elderly person who

needs assistance with preparing their meals. The anticipated outcome may be that the person received assistance and had meals prepared by their PCA in a manner that was satisfactory to the person.

COLUMN 4: REVIEW/RESOLUTION DATE:

The fourth column identifies when the CPOC will be reviewed. The review will determine whether the client's needs have been adequately met and whether the services continue to be necessary. The CPOC must be reviewed at least quarterly and updated yearly.

III. CPOC: TYPICAL WEEKLY SCHEDULE

This page is simply designed to provide a visual overview of service delivery during a typical week. This is a schedule for listing Medicaid, Medicare, private insurance, and other local, state, or federally funded services provided throughout the week. The intent of the service delivery schedule is to help reduce redundant or unnecessary service delivery. For example, a client who attends school would not need respite during school hours. Simply list the source of service provision when applicable. In addition, for waiver programs such as ADHC, simply marking in the time the client receives this service may be sufficient. The service delivery schedule is not to be used for daily monitoring of service delivery or monitoring of client's daily activities. However, the schedule is used by the reviewer to aid in giving a concise picture of the services addressed in the CPOC.

IV. CPOC: REQUESTED WAIVER SERVICES

This lists the client's required Medicaid funded services as described in the CPOC. All should be taken from the Service Plan and the Daily Schedule.

V. CPOC PARTICIPANTS

This section lists all participants who take part in the development of the CPOC and their title. This section addresses whether the client has an understanding of other alternative placement options. The signature of the case manager or responsible discipline, the client, and a witness are necessary here.

CARE PLAN ACTION

The last part of this section shows approval or denial of the CPOC. A Bureau of Health Standards and Financing representative (State/Regional Office) will check, date and sign this section.

HOME AND COMMUNITY CARE WAIVER SERVICES COMPREHENSIVE PLAN OF CARE

FORM HSS/HCW-11A (6/97) *Louisiana Department of Health and Hospitals*
BHSF - Health Standards Section

HOME AND COMMUNITY CARE WAIVER SERVICES
COMPREHENSIVE PLAN OF CARE

TYPE ☐ INITIAL ☐ UPDATE WAIVER TYPE ☐ ADHC ☐ E/DA ☐ MR/DD ☐ PCA DATE

CLIENT NAME/DOB	GUARDIAN (If applicable)
MEDICAID/MEDICARE NUMBER	RELATIONSHIP
ADDRESS	ADDRESS (If different)
CITY/STATE/ZIP	CITY/STATE/ZIP
PHONE	PHONE
CASE MANAGEMENT AGENCY	PROVIDER NUMBER (If applicable)
ADDRESS: STREET NO./P.O. BOX/RURAL ROUTE	CONTACT PERSON (e.g., Case Coordinator)
CITY STATE ZIP CODE	TELEPHONE NUMBER

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? ☐ YES ☐ NO

IF YES, PROPOSED LIVING SITUATION/ADDRESS:

I. CLIENT PROFILE

A. LEGAL STATUS

B. HEALTH STATUS

1. PHYSICAL

2. MEDICAL (To include current diagnosis)

3. PSYCHIATRIC/BEHAVIORAL CONCERNS:

C. MEDICATIONS (prescribed, allergic to, OTC, medical procedures)

MEDICATIONS/ MEDICAL PROCEDURES	DOSE	ROUTE	FREQUENCY	TO BE ADMINISTERED/ ASSISTED BY

D. NATURAL SUPPORTS: (List family, friends, and other community resources involved in supporting client on a frequent basis)

E. ADAPTIVE BEHAVIOR FUNCTIONING: (Current Status)

1. HEALTH AND SAFETY: CAN SELF-EVACUATE: Y N

2. SELF CARE:

3. HOME LIVING SKILLS:

4. COMMUNICATION:

5. SOCIAL SKILLS:

6. COMMUNITY USE:

7. LEISURE:

8. VOCATIONAL/ACADEMIC:

F. HABILITATION GOALS/NEEDED SUPPORTS: (Outcome Based)

1. HEALTH AND SAFETY: CAN SELF-EVACUATE: Y N

2. SELF-CARE:

3. HOME LIVING:

4. COMMUNICATION:

5. SOCIAL SKILLS:

6. COMMUNITY USE:

7. LEISURE:

8. VOCATIONAL ACADEMIC:

II. CPOC: SERVICE NEEDS

UTILIZE THIS FORM TO COMPLETE THE CASE MANAGEMENT AND PROVIDER PLAN OF CARE. USE THE LETTER TO DISTINGUISH EACH SERVICE AREA. THIS FORM SHEET MAY BE DUPLICATED AS NECESSARY.

SERVICES:

A. CASE MANAGEMENT
B. PERSONAL CARE ATTENDANT
C. RESPITE
D. RESIDENTIAL HABILITATION
E. SUBSTITUTE FAMILY CARE
F. DAY HABILITATION
G. HABILITATION SUPPORTED EMPLOYMENT
H. PRE-VOCATIONAL HABILITATION
I. ENVIRONMENTAL MODIFICATION
J. PERSONAL EMERGENCY RESPONSE
K. ASSISTIVE DEVICES
L. FAMILY/VOLUNTEER
M.NON-MEDICAID RESOURCES
N. SOCIAL SERVICES
O. MEDICAL SERVICES-NURSING
P. ACTIVITIES (e.g., GAMES, CRAFTS, READINGS)
Q. DIETARY
R. OTHER RESOURCES

GOALS OR NEEDED SUPPORT	SERVICE AREA(S)/ FREQUENCY	ANTICIPATED OUTCOME	REVIEW / RESOLUTION DATE

FORM HSS/HCW-11D-1 (6/97) CLIENT NAME_____ MEDICARE/MEDICAID # _____

II. CPOC: SERVICE NEEDS

UTILIZE THIS FORM TO COMPLETE THE CASE MANAGEMENT AND PROVIDER PLAN OF CARE. USE THE LETTERS ON PAGE 5 TO DISTINGUISH EACH SERVICE AREA. THIS FORM SHEET MAY BE DUPLICATED AS NECESSARY.

GOALS OR NEEDED SUPPORT	SERVICE AREA(S)/ FREQUENCY	ANTICIPATED OUTCOME	REVIEW / RESOLUTION DATE

III. CPOC: TYPICAL WEEKLY SCHEDULE

Specify in the appropriate time slot the services provided by Medicare/Medicaid , insurance carriers or other local, state, or federally funded services.

TIME	MON	TUES	WED	THUR	FRI	SAT	SUN
6:00AM							
7:00AM							
8:00AM							
9:00AM							
10:00AM							
11:00AM							
NOON							
1:00PM							
2:00PM							
3:00PM							
4:00PM							
5:00PM							
6:00PM							
7:00PM							
8:00PM							
9:00PM							
10:00PM							
11:00PM							
12:00AM							
1:00AM							
2:00AM							
3:00AM							
4:00AM							
5:00AM							

COMMENTS:

IV. CPOC: REQUESTED WAIVER SERVICES

List the client's requested services as described in the CPOC

PROVIDER NAME	PROVIDER NUMBER	SERVICE CODE	BILLING CODE	# OF UNITS	COST/ UNIT	WEEKLY COST	MONTHLY COST	START DATE	END DATE
				TOTAL:					

RM HSS/HCW-11G (6/97) CLIENT NAME _____ MEDICARE/MEDICAID # _____

V. CPOC: PARTICIPANTS

PARTICIPANTS INCLUDED IN THE CPOC ID TEAM CONFERENCE

PARTICIPANTS' SIGNATURES	TITLE

I REQUEST APPROVAL OF THIS PLAN OF CARE

_____ _____

CASE MANAGER/RESPONSIBLE DISCIPLINE SIGNATURE Date

☐ CLIENT UNDERSTANDS SERVICES OPTIONS ☐ CLIENT DOES NOT UNDERSTAND SERVICE OPTIONS

ıave 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 change in my income which might affect my financial eligibility.

_____ _____

Client Signature / Guardian Signature **Date**

_____ _____

Witness **Professional Title/Agency** **Date**

VI. CARE PLAN ACTION

☐ **APPROVED** CPOC BEGIN DATE _____ CPOC END DATE _____

☐ **DENIED**

COMMENTS:

_____ _____

ISS AUTHORIZED REPRESENTATIVE DATE

INSTRUCTIONS FOR THE CPOC REVISION REQUEST FORM

FORM HSS/HCW11-R (6/97)

CPOC REVISION REQUEST

____ ROUTINE ____EMERGENCY

CLIENT NAME_____ MEDICARE/MEDICAID #_____ _____DATE_____CPOC END DATE_____

CASE MANAGEMENT AGENCY_____ ADDRESS_____PHONE #_____

TYPE OF WAIVER: ___ADHC ___E/DA ___MR/DD ___PCA TYPE OF CHANGE REQUESTED: ___ CM ___PROVIDER ___SERVICES ___UNITS OF SERVIC

UTILIZE THIS FORM TO MAKE REVISIONS TO THE ORIGINAL CASE MANAGEMENT AND PROVIDER PLAN OF CARE. IN THE "REVISED FROM" COLUMN, CITE THE REFERENCED PAGE NUMBER, PROBLEM OR NEED NUMBER, AND DATE OF THE ORIGINAL APPROVED POC. USE THE LETTERS FROM PAGE 5 OF THE CPOC WHEN IDENTIFYING THE SERVICE AREA(S). THIS FORM MAY BE DUPLICATED AS NECESSARY.

REVISED FROM	GOALS OR NEEDED SUPPORT	SERVICE AREA(S)/ FREQUENCY	ANTICIPATED OUTCOME	DATE OF CHANGE

WHAT EVENTS LEAD TO THE NEED FOR THE REQUESTED CHANGE:

THIS CPOC CHANGE REQUEST HAS BEEN REVIEWED AND, IF ACCEPTED, WILL BECOME A PART OF THE CURRENT CPOC .

CM'S SIGNATURE_____ DATE_____

APPROVED___ DENIED____

HSS AUTHORIZED REPRESENTATIVE _____ _____DATE_____

Instructions for the CPOC Revision Request Form

HCW 11-R, dated 6/97 is to be used in the following instances:

* **Routine** - use this choice when requesting an additional service or deletion of a service. This choice should be checked when requesting additional services or units of service that are not needed as a result of an emergency.

* **Emergency** - use this choice when a revision to the CPOC has resulted from a sudden and unexpected situation that requires emergency measures, medical care/concerns and a prompt response.

Continue instructions as follows:

* **Client Name** - enter the name of the client.

* **Medicare/Medicaid #** - enter the client's Medicare/Medicaid number.

* **Date** - enter the date you are requesting a revision to the CPOC.

* **CPOC End Date** - enter the original date from the initially approved Comprehensive Plan of Care. (Ex.--CPOC begins 1-1-97, the ending date would be 1-1-98).

* **Case Management Agency** - enter the name of the case management agency currently coordinating client services.

* **Address** - enter the address of the case management agency.

* **Phone #** - enter the telephone number of the case management agency.

* **Type of Waiver** - check the waiver type that is applicable.

* **Type of Change Requested** - check the appropriate type of change that indicates what change is being requested.

The boxed area addresses the following columns:

Column 1 - **Revised From** -- enter the referenced page #, problem or need #, and the date of the current original approved CPOC.

Column 2 - **Goals or Needed Support** -- enter the client's problem or need that addresses the request for a revision.

Column 3 - **Service Area/Frequency** -- enter who will provide the service(s) (as indicated by the letters A - R, Page 4 of the CPOC) being addressed by the request for the revision(s). It is important to list natural supports, community, and non-Medicaid sources of services provision whenever possible. Included in this column is a description of the frequency of service delivery the provider will use to meet the client's need. For example, "assist with bathing once daily and hair washing three times weekly to be performed by family and the PCA".

Column 4 - **Anticipated Outcome** -- enter the desired outcome of training or needed support(s). This may reflect skill acquisition or may simply be a statement regarding the client's maintenance in the home and community with provided supports. For example, an elderly person who needs assistance with preparing their meals. The anticipated outcome may be that the person received assistance and had meals prepared by their PCA in a manner that was satisfactory to the person.

Column 5 - **Date of Change** -- enter the date of that the requested change will begin and end (especially when the requested change will be only for a specific period of time).

* **What Events Lead to the Need for the Requested Change** - write a statement that justifies the need for the requested change to the current original approved CPOC. Additional paper may be necessary and can be attached. Write the client's name and Medicaid number on any additional sheets should they become separated.

* **Case Manager's Signature** - enter the signature of the case manager that completes the requested revision.

* **Date** - enter the date the case manager signs the revision request form.

The last section is only completed by a representative of the Health Standards Section (State or Regional Offices). **DO NOT COMPLETE!**

A copy of the original Revision Form will be mailed to the case manager.

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

May 20, 1998

To: **All Medicaid Enrolled Providers**

From: Thomas D. Collins

Re: Statutorily Mandated Revisions to all Provider Agreements

The 1997 Regular Session of the Legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

(1) comply with all federal and state laws and regulations;
(2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
(3) have all necessary and required licenses or certificates;
(4) maintain and retain all records;
(5) allow for inspection of all records by governmental authorities;
(6) safeguard against disclosure of information in patient medical records;
(7) bill other insurers and third parties prior to billing Medicaid;
(8) report and refund any and all overpayments;
(9) accept payment in full for Medicaid recipients providing allowances for copay authorized by Medicaid;
(10) agree to be subject to claims review;
(11) the buyer and seller of a provider are liable for any administrative sanctions or civil judgements;
(12) notification prior to any change in ownership;
(13) inspection of facilities; and,
(14) posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing within ten (10) working days of the date of this letter that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

August 18, 1998

MEMORANDUM

TO: All Enrolled Medicaid Providers

FROM: Thomas D. Collins, Director of Bureau of Health Services Financing

RE: Office for Civil Rights Policy Memorandum

The Department of Health and Human Services, Office for Civil Rights, recently issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited-English proficient. Enclosed is the Health Care Financing Administration (HCFA) Civil Rights Compliance Statement which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of health care services through HCFA programs.

We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office of Civil Rights of the Department of Health and Human Services has previously advised HCFA that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

It has been asked that we share this policy statement with you and that you do likewise with health care providers and all others involved in the administration of HCFA programs.

Questions regarding this memorandum should be directed to Don Fontenot at 342-1316.

HEALTH CARE FINANCING ADMINISTRATION (HCFA)
CIVIL RIGHTS COMPLIANCE POLICY STATEMENT

The Health Care Financing Administration's vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all HCFA program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of HCFA funds. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; the Age Discrimination Act of 1975, as amended; the Americans with Disabilities Act of 1990, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all HCFA operating components. Promoting attention to and ensuring HCFA program compliance with civil rights laws are among my highest priorities for HCFA, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of HCFA programs.

HCFA, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. HCFA will, with your help continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, HCFA will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing HCFA publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office of Civil Rights, to initiate orientation and training programs on civil rights. HCFA will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, HCFA will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

HCFA's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries; i.e., our customers. We will enhance our communication with constituents, partners, and stakeholders. We will seek input from health care providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates, and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability.

Nancy-Ann Min DeParle

The following documents are included so you will know about correspondence sent to case management providers and waiver recipients regarding Medicaid waiver services.

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

February 9, 1999

TO: All Case Management Services Agencies

FROM: Thomas D. Collins
Director

RE: Complaint Process For Waiver Recipients

This is to inform you that the Bureau of Health Services Financing has advised all waiver recipients of their right to file complaints regarding the services received through the Medicaid Home and Community-Based Services Waiver Program (see copy of recipient letter attached).

It is important for you as case management providers to understand your role and responsibilities in the recipient complaint process and to ensure that your staff is also aware of this process. A notice has also been sent to all waiver services providers informing them of their roles in this process (See copy of waiver services provider notice attached).

It is the responsibility of the case manager or his designee to be reasonably accessible so as to enable the recipient or his family member/representative to report any valid concern(s) and/or complaint(s) regarding waiver services and to assist in the resolution of the recipient's concern(s) or complaint(s).

It is the role of the case manager to resolve complaints/concerns of less serious incidents or quality concerns except when the complaint/concern involves the case manager and/or case management agency. If a complaint is filed against a case manager by the recipient with the case management agency, it is the responsibility of the agency director or his designee to assist in resolution of the complaint. If a complaint is filed against the case management agency or case manager with the Home and Community-Based Services Waiver Complaint Manager, the agency director shall work with the Complaint Manager to resolve the complaint.

Medicaid services **shall not** be jeopardized or altered in any way following the report of a complaint by a waiver recipient.

As an enrolled Medicaid provider, you and your staff are required to comply with the Department's policy and procedures on confidentiality relative to complaints and complainants. By law, the case management agency and its staff are required to report incidents of abuse, neglect, exploitation, and extortion as defined in the recipient letter. Incidents may deal with such issues as health and safety, poor or inadequate services, and/or violations of the recipient's plan of care.

For your information, the following is a synopsis of the responsibilities of other participants in complaint process:

Waiver Service Provider (if applicable)

- Notifies case manager that a complaint has been received,
- Investigates recipient's complaint/concern,
- Tracks progress and resolution of complaint, and
- Takes corrective action, if appropriate.

Home and Community-Based Services Waiver Complaint Manager

- Notifies the recipient that their complaint has been received;
- Refers the complaint to the Regional Office for investigation, if appropriate;
- Tracks progress and resolution of complaint; and
- Reviews and approves the plan of correction.

Home and Community-Based Services Waiver Program—Regional Office

- Notifies the waiver service provider that a complaint has been received,
- Investigates the complaint, and
- Forwards finding to the Complaint Manager.

Copies of the letters sent to the recipients and waiver services providers explaining the complaint process are attached for your convenience. Please ensure that a copy of this notice is given to the appropriate staff within your agency. If you have any questions regarding the complaint process or this notice, you may contact the Division of Home and Community-Based Services Waiver Complaint Manager at 1-800-660-0488.

TDC/MM/re

attachments

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

February 9, 1999

TO: All Waiver Service Providers

FROM: Thomas D. Collins
Director

RE: Complaint Process for Waiver Recipients

This notice is to inform you that the Bureau of Health Services Financing has advised all recipients of the Medicaid Home and Community-Based Services Waiver Program of their right to file complaints regarding any aspect of waiver services. Such complaints may deal with issues of health and safety, poor or inadequate services, or assistance denied in violation of the recipient's plan of care. It is the responsibility of the waiver services provider to ensure that:

- Staff is trained regarding the recipient's rights and their responsibilities to meet the recipient's needs according to the plan of care;
- Staff is trained on the waiver complaint process;
- Staff appropriately reports incidents to you and the recipient's case manager. The case manager is responsible for assisting in the resolution of complaints; and
- Documentation of all complaints received and subsequent resolutions is maintained.

Medicaid services **shall not** be jeopardized or altered in any way following the report of a complaint by a waiver recipient.

As an enrolled Medicaid provider, you and your staff are required to comply with the Department's policy and procedures on confidentiality relative to complaints and complainants. By law, the waiver services provider and its staff are required to report incidents of abuse, neglect, exploitation, and extortion as defined in the recipient letter.

Copies of the letters sent to the recipients and case management agencies explaining the complaint process are attached for your convenience. If you have any questions regarding the complaint process or this notice, you may contact the Division of Home and Community-Based Services Waiver Complaint Manager at 1-800-660-0488.

TDC/MM/re

attachments

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

February 9, 1999

Dear Waiver Recipient:

Your satisfaction with the services you receive through the Home and Community-Based services waiver is important to us. Therefore, we wanted to make you aware of the process to follow should you need to file a complaint or alert our office to any concerns you may have about the quality of the services provided to you.

As a recipient of waiver services, you have every right to file a formal complaint if you are unhappy with any aspect of your waiver services. Please understand that all communications between you and this office are handled in a confidential manner. Additionally, the Medicaid services you receive will not be jeopardized or altered should you make a complaint.

Complaints are allegations that something has happened or might happen that has the potential for causing more than minimal harm. Some examples of complaints include health and safety related issues, poor or inadequate services, or assistance denied in violation of your plan of care. In the event that you may need to file a complaint, a list of definitions of serious complaint issues has been attached to this letter.

1. If you are in imminent danger or serious harm or injury is occurring:

   a. **Call 911 for emergency help; or**
   b. **Call your local law enforcement agency (Sheriff or City Police);**
   c. **Call the Division of Home and Community-Based Services Waivers at 1-800-660-0488 between 7:30 a.m. and 4:30 p.m., Monday through Friday;**
   d. **For children under the age of 18, call your local Child Protection Hotline;**
   e. **For adults age 18 to 59 or emancipated minors, call the Bureau of Protective Services at 1-800-898-4910 or 1-225-922-2250;**
   f. **For adults age 60 and over, call the Elderly Protective Services at 1-800-259-4990.**

2. To file a complaint regarding less serious incidents of any type or to alert the Department to any concerns you have about the quality of service provided to you, you should follow this procedure:

   a. The first step in resolving any problems with a specific provider is for you or your representative to contact the provider and discuss the concerns/problems that you are experiencing. This contact may be verbal or in writing.

   b. If the provider can not resolve your complaint or you do not feel comfortable working with the service provider, you may contact your case manager for assistance in resolving the problem. Please note, it is the responsibility of the case manager to assist each recipient in the resolution of complaints, as well as, to notify the Home and Community-Based Waiver Complaint Office of complaints made by waiver recipients regarding service providers.

   c. If your complaint can not be resolved at the case management agency level, you may contact the Home and Community-Based Services Complaint Manager directly or request that your complaint be referred to the Complaint Manager by your case management agency.

   d. If your complaint is regarding the case management agency, you may contact the Complaint Manager at the following address and telephone number:

      Home and Community-Based Services Waiver Complaint Manager
      534 Spanish Town Road
      P. O. Box 91030
      Baton Rouge, Louisiana 70821-9030
      1-800-660-0488

This office will work with you, the case manager, and/or the service provider(s) in question to take the necessary corrective actions for resolution of your complaint(s).

The Complaint Manager will refer your complaint to the appropriate Medicaid staff person and priority will be given to the most serious allegations for investigation. We will review all complaints received to determine the seriousness and accuracy of the allegations for investigation. When necessary, we may refer your complaint to another state agency or to a law enforcement agency for further investigation. You will always be notified of the outcome after the investigation is completed.

You have the right to request an informal hearing if you disagree with the outcome of our investigation. If you want an informal hearing, you must submit a request to the Complaint Manager (verbally or in writing) at the address or telephone number listed above within 30 days after receiving the investigation completion notice.

All efforts will be made to ensure that the complaint is resolved in the best interest of your rights and responsibilities under the Waiver Program.

If you have any questions or comments regarding the complaint process, please contact the Division of Home and Community-Based Services Waiver Complaint Manager.

Sincerely,

Thomas D. Collins
Medicaid Director

DEFINITIONS

Abuse is the infliction of physical or mental injury on a person.

Neglect is the failure of a caregiver to give the proper or necessary medical, surgical or any support or care necessary for the recipient's well-being.

Exploitation is the illegal use or management of an aged person's or disabled adult's funds, assets or property, or the use of that person's power of attorney or guardianship for one's own profit or advantage.

Extortion is the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation or abuse of legal or official authority.

Sexual Abuse is any sexual activity between a recipient and another person 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 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 the recipient is not competent to refuse.

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

HCBW-R-99-003

February 19, 1999

MEMORANDUM

TO: RECIPIENTS OF CASE MANAGEMENT SERVICES

FROM: THOMAS D. COLLINS, DIRECTOR

This letter is being sent to waiver recipients to provide you with additional information regarding changes in the Home and Community Based Waiver Program.

February 15, 1999 the Department began mailing out freedom of choice forms for MR/DD recipients. Each recipient must choose one of the contracted case management agencies listed on the freedom of choice form. The form should be returned as soon as possible in the self addressed stamped envelope. Recipients will be linked to their choice of providers for a period of six (6) months, and after that six (6) month period, if you wish, you may choose to change case management providers. If a choice is not made in 15 days from the date of the letter, you will be autoassigned to a provider. If you are autoassigned, you may choose another provider within thirty (30) days from the notification that you have been autoassigned.

DHH has begun conducting recipient satisfaction surveys through personal face to face home visits with waiver populations. The purpose of the visits is to see that the recipient is satisfied with the services they have been receiving and to ensure that they are quality services. Staff will be contacting you to schedule a home visit at a time and date convenient to you.

TC/JM/gv

The attached pages explain the process for obtaining prior authorization and billing for EPSDT Personal Care Services (PCS).

M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

David W. Hood
SECRETARY

MEMORANDUM

TO EPSDT PERSONAL CARE SERVICES PROVIDERS

FROM: Thomas D. Collins
Director

DATE: September 30, 1998

RE: NEW PRIOR AUTHORIZATION AND BILLING PROCEDURES FOR EPSDT PERSONAL CARE SERVICES (PCS)

Effective for dates of service November 1, 1998 and thereafter, The Medicaid Program will implement new procedures for prior authorization of billing for EPSDT Personal Care Services provided to recipients under the age of twenty-one. These procedures will replace the existing procedures used by EPSDT PCS Providers.

Prior authorization requests should be submitted on the newly created PA-14 Form. A copy of the PA-14 Form and instructions are attached. For your convenience, a blank PA-14 is also attached so that you may make copies of this form for use when requesting authorization for PCS services.

PRIOR AUTHORIZATION

To obtain prior authorization for a procedure, providers must complete a PA14-FORM and attach the following information:

- Form 90-L
- Prescription, Physician's Orders or Physician's Referral
- Plan of Care
- Social Assessment
- Any supporting documentation to warrant medical necessity.
- Daily Time Schedule Form

NOTE: IF THE RECIPIENT IS RECEIVING HOME HEALTH, RESPITE AND/OR ANY OTHER RELATED SERVICES, THE PCS PROVIDER CANNOT BE IN THE HOME AT THE SAME TIME.

The completed PA-14 Form, along with all necessary documentation to substantiate the medical necessity of the requested services, must be submitted to the Unisys Prior Authorization Unit (PAU), he following address:

UNISYS
P.O. Box 14919
Baton Rouge, La, 70898-4919
Attention: Prior Authorization (PCS Services)

Once the PA-14 form is received at Unisys, it will be screened for pertinent information prior to entry into the PA system. If the PA-14 form is incomplete or the required documentation is missing / incomplete, the form will be returned to the provider with a cover letter indicating what is needed.

After the PA-14 form is screened, a unique nine-digit prior authorization is assigned and the information is entered into the prior authorization system. Upon entry, the system will perform a series of front-end edits. It will check for a valid seven-digit Medicaid provider identification number, a valid thirteen-digit recipient identification number, recipient eligibility, a valid ICD-9 diagnosis code, age restrictions, etc. If any of the above do not clear the editing process, the system will deny the request automatically and generate a letter of denial to be sent to the provider and the recipient.

If the PA-14 form clears the above editing process, it will be reviewed by the Unisys review nurse and/or physician consultant(s) to determine medical necessity. Once the decision is made, the status of the review is entered into the prior authorization system and an approval or denial letter is generated that night to be sent to the provider and the recipient within the next two days. Once the notification of approval is received the provider may begin to render the services. **Approvals may be authorized for a period not to exceed six-months**.

If you are providing services previously approved under the old process for which you received an approval notification letter that include dates of service November 1,1998 and thereafter, you must submit a completed PA-14 form with the original approval letter attached in order to receive a PA number. Please send these requests to the Prior Authorization Unit at the above address. The PA Unit will issue a prior authorization approval letter with a nine-digit PA number to the provider of services and the recipient. **All new requests must be processed in accordance with the new procedures**.

RECONSIDERATION REQUEST

If the request is denied, a notification letter with the PA number is generated giving the reason(s) for denial and is sent to the provider and the recipient. The recipient's letter will have a notice regarding their rights to appeal. A provider may then submit a reconsideration request to the Unisys prior authorization unit and the physician consultant(s) will re-review the request. To request a reconsideration (RECON), providers should follow the instructions outlined below:

- Make a copy of the denial letter, and write the word RECON across the top of the denial letter, and write the reason for the request for reconsideration at the bottom of the letter.
- Attach all of the original documentation, as well as any additional information /documentation which supports medical necessity, to the letter.
- Mail the letter and all documentation to the Prior Authorization Unit at Unisys.

Unisys Physician Consultant(s) will re-review the request for medical necessity. If the request is approved or denied, another notification letter (with the same prior authorization number) will be generated and mailed to the provider and the recipient.

NEW BILLING INSTRUCTIONS

Hardcopy claims should be submitted on the HCFA 1500 claim form, as always. It will no longer be necessary to attach the approval letter to any claims prior authorized under the new process. This change will allow claims to be billed electronically. If you are billing via EMC, please remember to contact your software vendor to make the necessary updates for electronic billing.

The nine digit prior authorization (PA) number must be entered on the HCFA 1500 Claim Form in Block Number 23 (prior authorization number).

NOTE: ON THE HCFA 1500 CLAIM FORM IN BLOCK 24 -G (DAYS OR UNITS) ENTER THE NUMBER OF UNITS (NOT HOURS) BILLED.

Please keep this information for future reference. Providers may request PA-14 Forms from the Prior Authorization Unit at Unisys or you may make copies of the attached PA-14 Form.

Questions concerning prior authorization of services should be directed to the Unisys Prior Authorization Unit at (800) 807-1320.
Questions concerning claims/billing issues or policy should be directed to Unisys Provider Relations at (800) 473-5040.

MAIL TO:
UNISYS/LA. MEDICAID
O. BOX 14919
ATON ROUGE, LA 70890-4919

DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Health Services Financing
Medical Assistance Program
REQUEST FOR PRIOR AUTHORIZATION

NOTE: SHADED AREA IS FOR INTERNAL USE ONLY

PRIOR AUTHORIZATION TYPE	RECIPIENT 13-DIGIT MEDICAID ID NUMBER OR 16-DIGIT CCN NUMBER
[ ] 14--EPSDT PERSONAL CARE SERVICES	
RECIPIENT LAST NAME / FIRST / MI	DATE OF BIRTH
MEDICAID PROVIDER NUMBER (SEVEN-DIGITS)	DATES OF SERVICE FROM / THRU
STATUS CODES: 2 = APPROVED 3 = DENIED	

DIAGNOSIS INFORMATION:
PRIMARY CODE AND DESCRIPTION

SECONDARY CODE AND DESCRIPTION

PHYSICIAN/NURSE REVIEWER'S COMMENT SECTION:

PHYSICIAN/NURSE SIGNATURE:

Prescribing Physician's Name	Prescription Date

DESCRIPTION OF SERVICES

Procedure Code	Description	Requested Units	Authorized Units	Review Date	Status	P.A. Message/Denial Codes	
Z0200	EPSDT Personal Care Services, 30 min.						

Provider Name: _____

Address: _____

_____ State: _____ Zip Code: _____

Telephone Number: (___) ___ ____

Provider/Authorized Signature:

Date of Request: _____

PA 14 - FORM

INSTRUCTIONS FOR COMPLETING PRIOR AUTHORIZATION FORM (PA-14)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT UNISYS.

FIELD NO. 1 - Enter recipient's 13-digit Medicaid ID number or the 16-digit CCN number.

FIELD NO. 2 - Enter the recipient's last name and first name as it appears on their Medicaid Identification card.

FIELD NO. 3 - Enter the recipient's date of birth in month, day, year format (MMDDYY).

FIELD NO. 4 - Enter the provider's 7-digit Medicaid number, if associated with a group, enter the Attending provider number only.

FIELD NO. 5 - Enter in the From date of service block, the first day the service is requested to start. Enter in the Thru date of service block, the last day of service for that individual Treatment plan.

FIELD NO. 6- Enter the numeric ICD9-Diagnosis code (Primary & Secondary) and a narrative description of each.

FIELD NO. 7- Enter the name of the recipient's attending physician prescribing the services.

FIELD NO. 8- Enter the day the prescription, doctor's orders was written.

FIELD NO. 9- Enter the number of times the requested services will be performed during the Treatment plan. Calculate the total units requested (1 unit = ½ hour) by multiplying the Number of units per day times the number of days per week times the number of weeks Covered in the treatment plan. This will give the total units requested.
Below are two examples on the proper way to calculate the total units requested:

Example 1) Requesting four-hours per day for a six month period:

4 hrs. Per day = 8 units per day, 7 days a week, 26 weeks =
8 x 7 x 26 = 1456 total units requested

Example 2) Requesting two-hours per day on weekends and four-hours per day on Week days:

2 hrs. Per day (weekends)= 4 units per day, 2days a week, 26 weeks =
4 x 2 x 26 = 208 total units requested for weekends

4 hrs. Per day (weekdays) = 8 units per day, 5 days a week, 26 weeks =
8 x 5 x 26 = 1040 total units requested for weekdays

The total units requested would be the combination of the total weekend Units (208) and weekday units (1040), which would equal to 1248 total Units requested. This is the number (1248) to enter in Field Number 9.

FIELD NO. 10-Enter the name, mailing address and telephone number of the provider of service.

FIELD NO. 11& 12 – Provider/ Authorized Signature are required. Your request will not be accepted if Not signed and dated. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.

The attached pages from the EPSDT Health Services Provider Manual explain what EPSDT PCS (Personal Care Services) are and how providers obtain authorization and bill for the services.

SECTION 8
PERSONAL CARE SERVICES

SECTION CONTENTS

I. DESCRIPTION OF SERVICES

The Department of Health and Hospitals, Bureau of Health Services Financing has implemented a program that may provide Personal Care Services (PCS) to EPSDT eligibles (recipients up to age 21 years) meeting the medical necessary criteria for these services. Any enrolled Medicaid provider of MR/DD Waiver Personal Care Attendant (PCA) services is eligible to participate in this program.

EPSDT Personal Care Services by definition, may not include any medical tasks such as medication administration, tracheostomy care, feeding tubes, catheters. If such tasks are necessary, they must be requested under either the MR/DD Waiver PCA Program or the Home Health Program. BHSF will not accept the physician's delegation for EPSDT PCS providers to perform such medical tasks.

EPSDT PCS may not be provided to an EPSDT eligible receiving MR/DD Waiver Personal Care Attendant services until the waiver limit is exhausted.

The following information about the program will assist in providing EPSDT PCS in accordance with Medicaid policy and procedures:

A. Amount, Duration and Scope of EPSDT Personal Care Services (PCS)

1. EPSDT Personal Care Services (PCS) are defined as:

   a. tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when physical limitations due to illness or injury necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements.

   b. those services which prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

2. EPSDT Personal Care Services (PCS) include:

   a. Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with clothing;

b. Assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catherterization;

c. Assistance with eating and food, nutrition and diet activities, including preparation of meals for the recipient only;

d. Performance of incidental household services, only for the recipient, not the entire household, which are essential to the recipient's health and comfort in his/her home. Examples are:

1) Changing and washing the recipient's bed linens

2) Rearranging furniture to enable the client to move about more easily in his/her own room

3) Clean up of meal preparation for the recipient only

e. Accompanying, not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services;

f. EPSDT PCS are not to be provided to meet child care needs nor as a substitute for the parent in the absence of the parent.

1) If an EPSDT eligible is fourteen years of age or younger, child care arrangements must be specified when requesting approval for EPSDT PCS.

2) A parent or other care giver must be in the home with an EPSDT eligible fourteen years of age or younger.

g. EPSDT PCS are not allowable for the purpose of providing respite care for the primary care giver. Respite services are only available under the MR/DD Waiver for Home and Community-based Services.

h. EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education.

i. The following services are **not appropriate** for personal care and are **not reimbursable** as EPSDT Personal Care Services:

1) Insertion and sterile irrigation of catheters although changing of a catheter bag is allowed;

2) Irrigation of any body cavities which require sterile procedures;

3) Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate or severe skin problems;

4) Administration of medicine (as opposed to assisting with self-administered medication for EPSDT eligibles over eighteen years of age);

5) Cleaning of floor and furniture in an area not occupied by only the recipient. Example: Cleaning entire living area if the recipient occupies only one room of an area shared with other household members;

6) Laundry, other than that incidental to the care of the recipient. Example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the recipient's clothing or bedding;

7) Shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient, and not for items used by the rest of the household;

8) Skilled nursing services as defined in State Nurse Practices Act, including medical observation, recording or vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;

9) Teaching a family member or friend how to care for a patient who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;

10) Specialized nursing procedures such as insertion of nasogastric feeding tube, indwelling catheter, tracheostomy care, colostomy care, ileostomy care venipuncture and/or injections;

11) Rehabilitative services such as those administered by a physical therapist;

12) Occupational therapy, speech pathology services, audiology services and respiratory therapy;

13) Teaching a family member or friend techniques for providing specific care;

14) Palliative skin care with medicated creams and ointments and/or requires routine changes of surgical dressings and/or dressing changes due to chronic conditions;

15) Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;

16) Specialized aide procedures such as:

- rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services);
- measuring/recording patient vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids;
- specimen collection;

- special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas;

17) Home IV therapy;

18) Custodial care or provision of only instrumental activities of daily living tasks or provision of only one (1) activity of daily living task;

19) Personal comfort items, durable medical equipment, oxygen, orthotic appliances or prosthetic devices;

20) Drugs provided through the Louisiana Medicaid pharmacy program;

21) Laboratory services; or,

22) Social Worker visits.

B. Conditions for Provisions of EPSDT Personal Care Services (PCS)

Conditions for provisions of EPSDT Personal Care Services (PCS) are as follows:

1. Medicaid Eligibility

The person must be a categorically eligible Medicaid recipient birth through twenty years of age (EPSDT eligible) and have been prescribed EPSDT PCS as medically necessary by a physician. The physician shall specify the health/medical condition which necessitates EPSDT Personal Care Services;

2. Medical Necessity

An EPSDT eligible must meet medical necessity criteria as established by BHSF which shall be based on **criteria equivalent to at least an Intermediate Care Facility 1 (ICF-1) level of care;** and be impaired in at least two activities of daily living tasks, as determined by BHSF.

a. To establish medical necessity, the EPSDT eligible must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.

b. If the parent(s) is in the home and is not providing care to the EPSDT eligible, medical documentation for the parent or guardian must be submitted with the request so that BHSF may determine that the parent(s) is physically unable to provide personal care services to the child.

c. When determining whether a recipient qualifies for EPSDT PCS, consideration must be given not only to the type of services needed, but also the availability of family members and/or friends who can aid in providing such care. *Plans of care shall specify such information in the social history.* EPSDT PCS are not to function as a substitute for child care arrangements.

3. Referral

EPSDT Personal Care Services **must be prescribed** by the recipient's attending physician initially and every 180 days after that (or rolling six months), and when changes in the Plan of Care occur.

a. The physician shall only sign a fully completed plan of care which shall be acceptable for submission to BHSF only after the physician signs and dates the form.

b. **The physician's signature must be an original signature and not a rubber stamp.**

4. Plan of Care

a. The recipient's choice of a Personal Care Services provider may assist the physician in developing a plan of care which shall be submitted by the physician for review/approval by BHSF or its designee.

b. The plan of care must specify the personal care service(s) to be provided (i.e., activities of daily living for which assistance is

needed) and *the minimum and maximum frequency* and *the minimum and maximum duration* of each of these services. Dates of care not included in the plan of care or services provided before approval of the plan of care by BHSF are not reimbursable.

c. The recipient's attending physician shall review and/or modify the plan of care and sign off on it prior to the plan of care being submitted to BHSF. A copy of the physician's prescription or referral for EPSDT PCS must accompany the request for authorization and also be retained in the personal care services provider's files.

d. A new plan of care must be submitted at least every 180 days (rolling six months).

1) Must be approved by the recipient's attending physician.

2) The plan of care must reassess the patient's need for EPSDT PCS services. It must include:

- any updates to information which has changed since the previous assessment was conducted; and
- an explanation of when and why the change(s) occurred.

3) Changes in the patient's medical condition may necessitate revisions of the plan of care because:

- an additional type of service may be needed;
- an increase or decrease in frequency of service may be needed; or,
- an increase or decrease in duration of service may be needed.

4) Documentation for a revised plan of care is the same as for a new plan of care.

5) A new "start date" and a new "reassessment date" must be established at the time of reassessment.

6) Request for EPSDT PCS must be requested in increments of up to six months duration.

e. Request for EPSDT PCS must be accompanied by the following documents:

1) Copy of the recipient's Medical Eligibility Card;

2) Physician's referral for PCS and physician approval of plan of care prepared by PCA agency;

3) Form 90-L completed by the attending physician within the last 90 days to document recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1 along with a completed face-to-face medical assessment;

4) Social Assessment Form;

5) EPSDT PCS Daily Schedule Form;

6) Plan of care approved by recipient's referring physician and a social history which provides the following information:

- Recipient name, Medicaid ID number, date of birth and address;
- Date EPSDT PCS services requested to start;
- Provider name, Medicaid provider number and address of PCA agency;
- Name and phone number of someone from the provider agency that may be contacted, if necessary, for additional information;
- Medical reasons supporting the need for PCS (must

be accompanied by appropriate medical documentation for recipient and parent/care giver, if disabled);

- Goals for each activity;
- Specific activities (bathing, dressing, eating, etc.) with which PCS provider is to assist the recipient; number of days services are required each week; number of hours required for each activity for each day; times that services will be needed (i.e., 8-10 a.m. and 4-5 p.m.);
- Other in-home services utilized or requested for recipient (i.e., MR/DD Personal Care Attendant or Respite services, Home Health services—specify whether nurse, aide or Physical Therapy services, OCDD sponsored care, home teacher, etc.);
- For children 14 years of age and younger, child care arrangements must be specified (parent/relative/paid care giver) and if applicable, specify the personal care activities for which the parent or other care giver require the assistance of the PCS provider due to an inability to perform these services alone. The reason the parent cannot provide the services necessary should be specified and appropriate medical documentation attached to the request.

f. **The provider may not initiate services or changes in services under the plan of care prior to approval by BHSF.**

6. Prior Authorization

EPSDT Personal Care Services shall be prior authorized by the BHSF or its designee.

Requests for prior approval of EPSDT Personal Care Services should be submitted to the following address:

Bureau of Health Services Financing
Program Operations Section
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030
Attention: EPSDT Program Coordinator

The request shall be reviewed by BHSF's physician consultant and a decision rendered as to the approval of the service. A letter will be sent advising of the agency's decision.

7. Where will PCS be provided?

EPSDT PCS must be provided in the recipient's home or in another location outside the recipient's home, if it is medically necessary for the recipient to be there.

a. The recipient's home is defined as the recipient's own dwelling, an apartment, a custodial relative's home, a boarding home, a foster home, a substitute family home or a supervised living facility.

b. Institutions such as a hospital, institution for mental diseases, nursing facility, intermediate care facility for the mentally retarded or a residential treatment center are not considered a recipient's home.

8. Who provides PCS?

PCS must be provided by a licensed PCA agency which is duly enrolled as a Medicaid provider. Staff assigned to provide personal care services shall not be a member of the recipient's immediate family.

a. Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law or any individual acting as parent or guardian of the recipient.

b. PCS may be provided by a person of a degree of relationship to the recipient's home, or, if he/she is living in the recipient's home solely because his/her presence in the home is necessitated by the amount of care required by the recipient.

9. Limits of PCS

EPSDT PCS are limited to a maximum of four (4) hours per day per recipient as prescribed by the recipient's attending physician and prior authorized by BHSF or its designee. Extensions of this limit may be requested if additional units of service are documented to be medically necessary and are approved as medically necessary by BHSF or its designee.

II. STANDARDS FOR PAYMENT

A. EPSDT PCS may be provided only to EPSDT eligibles and only by a staff member of a licensed PCA agency enrolled as a Medicaid personal care services provider.

1. A copy of the current PCA license must accompany the Medicaid application for enrollment as a PCA provider.

2. Additional copies of current licenses shall be submitted to Provider Enrollment as they are issued for inclusion in the enrollment record. The provider's enrollment record must include a current PCA license at all times.

3. Enrollment is limited to providers in Louisiana and out-of-state providers only in trade areas of states bordering Louisiana (Arkansas, Mississippi, and Texas).

B. The unit of service billed by EPSDT PCS providers shall be one-half hour, exclusive of travel time to arrive at the recipient's home. The entire 30 minutes of the unit of time shall have been spent providing services in order to bill a unit. Payment can be made by Medicaid only for the hours of half-hours during which the provider is actually performing EPSDT PCS.

C. All EPSDT PCS must be prescribed by a physician at least every 180 days (rolling six months).

D. EPSDT PCS shall be prior authorized by BHSF by a Form 90-L, a Social Assessment Form, and a plan of care enumerating the tasks to be performed and the medical conditions requiring such personal care services submitted by the provider and approved by the physician, for no more than a six (6) month period.

1. Services must be reauthorized at least every six months and a new plan of care, a new 90-L, and a new Social Assessment Form must be submitted with each subsequent request for approval.

2. Amendments or changes in the plan of care should be submitted as they occur.

E. The PCA agency is responsible for ensuring that all individuals providing personal care services meet all training requirements applicable under state law and regulations.

1. The personal care staff member must successfully complete the applicable examination for certification for PCA.

2. Documentation of the personal care staff member's completion of all applicable requirements shall be maintained by the PCA provider.

F. The recipient shall be allowed the freedom of choice to select an EPSDT PCS provider.

G. Documentation for EPSDT PCS provided shall include at a minimum, the following:

1. Documentation of approval of services by BHSF or its designee

2. Daily notes by PCS provider noting:

   a. date of service,
   b. services provided (checklist is adequate),
   c. total number of hours worked,
   d. time period worked,
   e. condition of recipient,
   f. service provision difficulties,
   g. justification for not providing scheduled services,
   h. any other pertinent information

3. There must be a clear audit trail between the prescribing physician, the PCA provider agency, the individual providing the personal care services to the recipient, and the services provided and reimbursed by Medicaid.

H. Agencies providing EPSDT PCS shall conform to all applicable Medicaid regulations plus all applicable laws and regulations by federal, state and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, OSHA requirements, liability insurance, worker's compensation, occupational licenses, etc.

I. EPSDT PCS provided to meet child care needs or as a substitute for the parent in the absence of the parent shall not be reimbursed. The plan of care submitted must document:

1. For children fourteen (14) years of age and younger, that there will be a care giver in the home (parent/relative or paid child care); and

2. The care that the care giver is providing or is unable to provide.

J. EPSDT PCS provided for respite to the primary care giver shall not be reimbursed.

K. EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services provided by or must be provided by the Department of Education.

III. REIMBURSEMENT METHODOLOGY FOR EPSDT PCS

A. Maximum Unit Rate

EPSDT PCS shall be paid the lesser of billed charges or the maximum unit rate set by BHSF. The maximum unit rate is $3.74 per half hour unit.

1. This maximum rate was set based on the federal minimum hourly wage as of October 1, 1996, plus 22% for fringe benefits (insurance, worker's compensation, unemployment, etc.); plus 24% for agency administration and operating costs based on BHSF administrative and operating costs; plus a profit factor of 4% of the above calculated rate.

2. This rate will be adjusted whenever the federal minimum wage is adjusted.

B. Billing for EPSDT PCS

1. Form Used to Bill

For approved EPSDT PCS, the provider should bill using HCFA 1500. See Section 7, Claims Filing for a copy of this form and instructions on completing it.

2. Procedure Code

For approved EPSDT PCS, the provider should bill using the procedure code **"Z0200 - EPSDT Personal Care Service".**

3. Other Requirements for Billing for EPSDT PCS

a. The approval letter from BHSF ***must*** be attached to ***each*** hardcopy claim sheet when submitted to the fiscal intermediary for payment.

NOTE: If multiple claim sheets are submitted at the same time, a copy of the approval letter must be attached to ***each*** sheet.

1) The approval letter will be used to verify that the billed services have been approved.

2) If a claim for EPSDT PCS is submitted without the approval letter from BHSF attached, it will automatically be denied with error code "191" (Procedure Requires Prior Authorization).

3) If the dates of services on the claim are not within the dates in the approval letter, the claim will be denied with error code "193" (Date On Claim Not Covered by PA).

4) If an incorrect number of units are billed, the claim will be denied with error code "194" (Claim Exceeds Prior Authorized Limits).

5) ***Hours may not be "saved" to be used later or in excess of the number of hours specified in the approval letter.***

b. Remember: Each unit represents an half-hour of PCS.

c. ***Billing for PCS must be hardcopy*** or claim will be automatically denied. This hardcopy claim must be mailed to:

Unisys
Post Office Box 91020
Baton Rouge, LA 70821

See Section 7, Claims Filing.

IV. MONITORING AND DOCUMENTATION FOR PCS

Providers must make available to BHSF all records of EPSDT PCS provided to children with special health needs. The documentation must be maintained for at least **three years** from the date of payment on all children for whom claims have been submitted.

A. Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying the Plan of Care including the tests performed and results, copies of evaluation and diagnostic assessment reports signed by the individual performing the test and/or interpreting the results.

B. Copies of the Plan of Care, Social Assessment Form 90-L, EPSDT PCS Daily Schedule Form and Physician's Order for EPSDT Personal Care Services.

C. Documentation of approval of services by BHSF or its designee.

D. Documentation of the provision of treatment services by the Personal Care Services worker including dates and times of services, log books, reports on services provided and signed by the individual providing the services and the supervisor, if appropriate.

E. All billing records must be maintained for three (3) years.

EPSDT Personal Care Services—Social Assessment
Must Be Submitted In Addition to Form 90-L

RECIPIENT NAME:_____ MEDICAID #_____

1. HOUSEHOLD COMPOSITION:

Name	Age	Relationship	School/Work?

2. PRIMARY CAREGIVER ASSESSMENT:

Name: _____ Age_____ Relationship_____Phone_____

Does Primary Caregiver have physical or mental limitations which would affect his/her ability to care for the recipient?
☐Yes ☐No If yes, explain and attach medical documentation of limitations:

_____

_____

Will the primary caregiver supervise the PCS worker? ☐Yes ☐No

3. CHILDCARE ARRANGEMENTS:

Age of the recipient: _____ If fourteen years or younger, explain childcare arrangements when the parent is gone from the home. (ie., when parent is at work, before/after school when parent works, or when parent is away on errands).

_____

_____

4. RECIPIENT ASSESSMENT:

Does recipient attend school or work? ☐Yes ☐No If yes, specify hours attended and name of school or

work:_____

Is recipient ☐ Verbal ☐ Nonverbal?
Does recipient utilize adaptive equipment? ☐Yes ☐No
If yes, specify what type equipment:_____

_____

an recipient direct his/her own care? ☐Yes ☐No
If no, is primary caregiver or other caregiver in home? ☐Yes ☐No

Is recipient on medication: ( ) Yes ( ) No
If yes, who gives medication?_____

5. DIETARY FACTORS:

Who prepares meals?_____

Type of meals and number per day:_____
Assistive devices for eating (feeding tube, other): ( ) Yes ( ) No
If yes, specify:_____

6. HOME ENVIRONMENT:

Access (describe stairs, doors, walks, etc): _____

_____

Living Space:_____

_____

Location (rural, urban, on bus line, etc.):_____

_____

7. **Family Interpersonal Relationships:** Which family members assume major responsibilities for caring for recipient and what tasks do they perform?

_____

_____

8. SOCIAL SUPPORT SYSTEM: Are there other friends or relatives that assist in caring for the recipient or in giving relief to the primary caregiver?

_____

_____

9. OTHER SERVICES: What other services is the recipient receiving at this time (home health, respite, etc.)?

_____

_____

10. PCS SERVICES: What is the name of the agency that will provide PCS services?

_____

Signature(s) of person(s) completing assessment:

_____ Date:_____

_____ Date:_____

EPSDT PCS DAILY SCHEDULE

Client Name_____ Medicaid #_____

Specify hours of all services recieved by recipient. This includes EPSDT PCS as well as other services such as home health aide or nurse, respite or PCA from waiver or contract, physical therapy, etc. Be certain to show times the recipient is in school.

TIME	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
NOON							
1:00 PM							
2:00 PM							
3:00 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							
12:00 PM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
Comments							

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Frederick P. Cerise, M.D., M.P.H.
SECRETARY

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
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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Frederick P. Cerise, M.D., M.P.H.
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September 22, 2004

BCSS-ADM-04-006
BCSS-C-04-021
BCSS-P-04-018

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M. J. "Mike" Foster, Jr.
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
David W. Hood
SECRETARY

BCSS-P-03-012

March, 2003

TO: Providers of Home and Community-Based Services

FROM: Barbara C. Dodge, Director
Bureau of Community Supports and Services

RE: Medicaid Electronic Claims Submittal
HCFA 1500

This is to provide notification that your billing software must be capable of utilizing and sending data in all of the available fields on the HCFA 1500. This is necessary to accommodate system changes related to requirements of the Health Insurance Portability and Accountability Act (HIPAA). Failure to ensure that your software includes this capability could result in the denial of future claims.

The above requirement is an interim change; full compliance with HIPAA will be required for billing after October 16, 2003. For more information concerning HIPAA requirements, you may visit the DHH website at www.dhh.state.la.us/hipaa/index2.htm, or the website for the Centers for Medicare and Medicaid Services at www.cms.hhs.gov/hipaa/hipaa2/default.asp.

Thank you for your cooperation in this matter.

c: BCSS State Office
BCSS Regional Offices
SRI