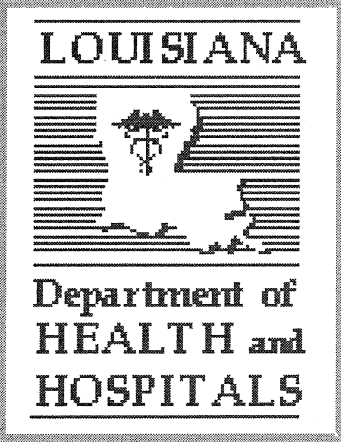
SUPPORTS WAIVER PROVIDER MANUAL

MEDICAID

Department of Health and Hospitals
Bureau of Health Services Financing



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OVERVIEW

The Supports Waiver is a 1915(c) waiver designed to provide Home and Community-Based Waiver services to participants who otherwise would require the level of care of an intermediate care facility for the developmentally disabled (ICF/DD). An ICF/DD is also referred to as an ICF/MR. The Supports Waiver is designed for participants who have access to supports and services through family and community resources that are sufficient to assure their health and welfare.

The goal of the Supports Waiver is to create options and provide meaningful opportunities that enhance the lives of men and women ages 18 and over with developmental disabilities.

The objectives of the Supports Waiver are to:

- Promote independence for participants by providing services that meet the highest standards of quality and national best practices and ensure the participant's health and safety through a comprehensive system of safeguards;

- Offer an alternative to institutionalization by providing an array of services and supports. These supports and services promote community inclusion and independence by enhancing and not replacing existing informal networks;

- Support participants and their families to exercise their rights and share responsibility for their programs regardless of the method of service delivery;

- Offer access to services on a short term basis that would protect the health and safety of the participant if the family or other care giver were unable to continue to provide care and supervision;

- Utilize personal outcome interviews and standardized assessment tools to assist in the creation of participant-centered service plans that reflect personal choices and needs.

Services are based on the participant's need and are developed using a person centered planning process. A support coordinator assists the participant in the planning process. Each participant will be administered the Supports Intensity Scale (SIS) and Louisiana Plus (LAPlus) or another standardized assessment prior to the beginning of the planning process.

Information from the assessment and personal outcome interviews with the participant, his/her responsible party(s), and other team members of the participant's choice form the foundation for

a Comprehensive Plan of Care (CPOC). The CPOC identifies all a participant's needs, both non-funded and funded. Services identified in this manual are provided based on need and must be specified in the Office for Citizens with Developmental Disabilities Waiver Supports and Services (OCDD/WSS) approved CPOC.

Supports Waiver services are provided as a supplement to regular Medicaid State Plan services and natural supports. All natural supports, available community resources, and applicable Medicaid State Plan services must be exhausted prior to utilization of waiver funding. This waiver is not a lifetime entitlement or fixed annual allocation.

All waiver services are accessed through the participant's support coordination agency. Support coordination and providers of direct services are selected through a freedom of choice process. While support coordination is not a Supports Waiver service, it is a requirement of waiver participation that all participants receive support coordination.

The State will refuse entrance to the waiver to any qualified individual when the expected cost of home and community-based services would exceed $26,000.00 in a service plan year.

Supports Waiver opportunities will initially be offered to individuals who are currently receiving state general funded vocational and habilitative services through the OCDD and human service districts/authorities. Subsequent waiver opportunities will be offered to people waiting for state general funded vocational and habilitative services through the OCDD on a first-come, first-served basis. These two groups are known as "the target group".

In accordance with the OCDD/WSS Policy and Procedure manual, Chapter 5, Request for Services Registry (RFSR), once everyone in the target group has been served, waiver opportunities will be offered to any eligible person on a first-come, first-served basis.

An individual may receive waiver services and remain on any other home and community-based waiver RFSR for which he/she may qualify. However, a person may only receive services from one waiver at a time. Therefore, someone receiving services through another home and community-based waiver may not receive Supports Waiver services at the same time he/she is receiving services through the other waiver.

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

ELIGIBILITY CRITERIA

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

- Meet the definition for a developmental disability as defined in The Developmental Disability Law, Louisiana R.S 28:451.1-455.2, which is as follows:

  Developmental Disability means either a severe chronic disability of a person that:
  - Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;
  - Is manifested before the person reaches age twenty-two;
  - Is likely to continue indefinitely;
  - Results in substantial functional limitations in three or more of the following areas of major life activity:
    - Self-care;
    - Receptive and expressive language;
    - Learning;
    - Mobility;
    - Self-direction;
    - Capacity for independent living;
    - Economic self-sufficiency;
  - Is not attributable solely to mental illness; and

  - Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

    Or

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

- Meet financial eligibility for Medicaid Home and Community-Based Waiver services. Meet the requirements for Intermediate Care Facility for the Mentally Retarded level of care, which requires active treatment of mental retardation or a

developmental disability under the supervision of a qualified mental retardation or developmental disability professional.

- The health and welfare of the person must be able to be assured within the cost limit.

DISCHARGE CRITERIA

Participants will be discharged from the Supports Waiver if one of the following criteria is met:

- Loss of Medicaid eligibility as determined by the parish Medicaid office.
- Loss of ICF/DD LOC as determined by the OCDD/WSS regional office.
- Incarceration or placement under the jurisdiction of the penal authorities or courts.
- Admission to an acute care hospital, rehabilitation hospital, ICF/DD facility or nursing facility with the intent stay longer than 90 consecutive days.
- Change of residence to another state with the intent to become a resident of that state.
- Admission to an acute care hospital, rehabilitation hospital, ICF/DD facility or nursing facility with the intent to stay longer than 90 consecutive days.
- Continuity of services is interrupted as a result of the participant not receiving a waiver service during a period of thirty (30) consecutive days.
- Determination by the OCDD/WSS regional office that the participant's health and safety cannot be assured through the provision of waiver services.
- The participant and/or responsible party(s) fail to cooperate in the eligibility determination process, the annual development of the CPOC or do not uphold the responsibilities outlined in form OCDD/WSS-RF-02-047REQ.

HOSPICE SERVICES

Waiver recipients may receive hospice and waiver services concurrently. However providers must ensure that no services are duplicated. The fact that that diagnosis for the hospice and waiver service are different or that the providers are not in the recipient's home at the same time is not sufficient to ensure that there is no duplication of services. Providers must adhere to the following policy when providing services to a recipient who is receiving both services:

- The waiver provider, hospice provider and waiver support coordinator must develop a coordinated plan of care.

- The waiver provider must prepare the waiver plan of care to include all services that the waiver provider would have provided had the Medicaid recipient not been in the hospice program.

- The waiver provider must modify the waiver plan of care to ensure there is no duplication of services for those services held in common that would be necessary to treat the terminal illness and related conditions. For example, the waiver provider must modify or adjust hours in the waiver plan of care if the hospice agency provides personal care, attendant care, or homemaker hours to treat the terminal condition.

- Both waiver and hospice providers must thoroughly document the required distinction between the services provided.

  Note: The hospice provider will provide those services that intermingle between diagnoses. Approved waiver services shall be reduced by the appropriate level.

RIGHTS AND RESPONSIBILITIES S

Applicants for and participants of HCB waiver services are afforded specific rights and responsibilities as addressed in the OCDD/WSS Rights and Responsibilities for Individuals Requesting Home and Community-based Waiver Services form (OCDD/WSS-RF-02-047REQ) and the Louisiana Developmental Disability Law, LA R.S. 28: 452.1.

Participant Rights

Participant rights include but are not limited to:

- Be treated with dignity and respect.
- Participate in and receive person-centered, individualized planning of supports and services.
- Receive accurate and complete information that includes a written explanation of the process of evaluation and participation in a home and community-based waiver, including how he/she qualifies for it and what to do if he/she is not satisfied.
- Work with competent, capable people in the system.
- File a complaint or grievance with a support coordination agency or direct service provider regarding the services received.
- File a complaint or grievance with the Department of Health and Hospitals (DHH) regarding services by calling the complaint hotline at 1-800-660-0488.
- Refuse to sign any paper that he/she does not understand or is not complete.
- Have a choice of service/support providers when there is a choice available.
- Receive services in a person-centered way from trained competent care givers.
- Have timely access to all approved waiver services that are identified on the CPOC.
- Receive in writing any rules, regulations, or other changes that affect his/her participation in a home and community-based waiver.

- Receive information explaining support coordination and direct service provider responsibilities and their requirements in providing services to participants.
- Receive an explanation of all available Medicaid services and how to access these services.

Participant Responsibilities

The participant and/or responsible party:

- Will actively participate in planning and making decisions on these supports and services that he/she needs.
- Will cooperate in the planning for all the services and supports that he/she will be receiving.
- Will provide all necessary information about himself/herself. This will help the support coordinator to develop a CPOC that will determine what services and supports the participant needs.
- Will not ask providers to violate the law or Medicaid regulations
- Will cooperate with the OCDD/WSS staff and the participant's support coordinator by allowing them to contact him/her by telephone, and visit with him/her face-to-face at least quarterly, or as necessary. Necessary visits include pre-certification visits to assist the OCDD/WSS in providing the best services and supports possible, regular visits to assure the CPOC is sufficient to meet the participant's needs, visits resulting from complaints to the OCDD/WSS, and visits needed to assure the participant is receiving the services as reported by his/her providers.
- Will cooperate with DHH and Centers for Medicare and Medicaid Services (CMS) staff in monitoring activities.
- Will immediately notify his/her support coordinator and direct service provider(s) if his/her health, medications, service needs, address, telephone number, alternate contact number, or financial situation changes.
- Will immediately notify the local Medicaid parish office of changes in address, telephone number or financial situation.

- Will help the support coordinator to identify any natural and community supports that would be of assistance in meeting his/her needs.

- Will follow the requirements of the program, and if information is not clear, will ask the support coordinator or direct service provider to explain it to him/her.

- Will verify that he/she has received the waiver and medical services reported by the provider, including the number of hours his/her direct service provider works. Any differences are to be reported to the Bureau of Health Services Financing (BHSF) Health Standards Section (HSS) Complaint Line at 1-800-660-0488.

- Will sign and date an OCDD/WSS form RF-02-047REQ acknowledging that in the event that waiver services are not .received for more than thirty (30) days the participant understands that his/her waiver case may be closed for non-receipt of services.

- Will obtain a BHSF form 90-L (Request for Medical Eligibility Determination) completed by a licensed physician each year.

- Must provide a psychological assessment to meet eligibility criteria.

- May request different waiver service if current services no longer meet the criteria outlined on the waiver fact sheet that he/she received.

ACCESSING SERVICES

The support coordination agency and the support coordinator, the participant and his/her responsible party(s) coordinate all non-funded and funded services that are needed by the participant.

Participants are sent a Freedom of Choice (FOC) list of support coordination agencies. All services are accessed through the selected support coordination agency.

The support coordinator develops a CPOC with the participant, his/her responsible party(s), the direct service provider(s) and other support team members using a person-centered planning process.

The support coordinator will provide the participant with a list of agencies to select a direct service provider through a FOC process. The direct service provider's involvement begins upon notification from the support coordination agency that the participant has chosen their agency to deliver waiver services.

Supports and services are planned according to the needs of the participant, not for the convenience of the provider. They are provided as a supplement to Medicaid State Plan services and natural supports which must be exhausted prior to utilizing waiver funds. Only services on the approved CPOC will be paid. This waiver is not a lifetime entitlement or fixed annual allocation.

Any change in the CPOC will occur only at the request of the participant and his/her responsible party(s) and be directed to the support coordinator. Changes in the CPOC will not be made solely on request of a provider.

All waiver services must be prior and post authorized (PA). Until the direct service provider receives an approved PA, no service(s) will be paid. Medicaid cannot reimburse for services rendered without approved PAs.

SERVICES

Support Waiver services are designed to enhance the participant's independence through involvement with employment and other community activities. All services must be based on need documented in the approved Comprehensive Plan of Care (CPOC), and provided within the State of Louisiana.

Supported Employment

Supported employment is intensive, ongoing supports and services necessary for a participant to achieve the desired outcome of employment in a community setting where the majority of the persons employed do not have disabilities. Supported employment is also available to participants who are self-employed. Participants utilizing supported employment may need long-term supports for the life of their employment due the nature of their disability and natural supports do not meet this need.

Supported employment provides supports for individual job, group employment, self-employment or microenterprise in the following areas:

- Job assessment, discovery and development; and
- Initial job support and job retention including assisting in personal care with activities of daily living in the supported employment setting.

Prior to receiving Job Assessment, Discovery and Development services through the waiver, the participant must apply for, and exhaust any similar services available through Louisiana Rehabilitation Services (LRS) or the Individuals with Disabilities Education Act if the participant is still attending high school. Services will be considered unavailable if a participant applies, is eligible and qualifies for LRS services but is put on a waiting list. However, if there is no waiting list, the participant must utilize LRS services prior to receiving initial job support and retention through the waiver, regardless of the amount of time it takes for the participant to begin receiving job assessment, discovery and development services through LRS.

There must be documentation in the participant's file that these services are not available from programs funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act and those covered under the Medicaid State Plan.

When supported employment is provided at a work site where a majority of the persons employed do not have disabilities, payment is only made for the adaptations, supervision and training required by participants receiving the service as a result of their disabilities. It does not include payment for the supervisory activities rendered as a normal part of the business setting.

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

Staffing Requirements

Supported employment may be billed when furnished by a co-worker or other job-site personnel provided the services furnished are not part of the normal duties of the worker or other personnel, and these individuals meet the pertinent qualifications of a provider of this service.

Exclusions

Participants receiving Supported Employment services may also receive Day Habilitation or Prevocational Services, but these services cannot be billed for in the same service day. Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

Job Assessment, Discovery and Development

Job assessment, discovery and development is the process of:

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

Staffing Ratios

Rates are paid per participant, not per group. Individual and group employment assessment must be done on a one staff to one participant ratio. Individual and group employment job discovery and development may be billed on a one staff to multiple participant ratios. The staff ratio needed to support the participant must be documented on the CPOC.

When individual job discovery and development is billed on one staff to multiple participant ratios, post authorization documentation must show individual outcomes. For example, if an employment specialist bills for two participants on the same day for the same time period, post authorization documentation must show that job development efforts were made for each individual according to his/her identified specific career interests. If both participants identified career interests are restaurant work, then billing could reflect a visit to one restaurant on behalf of both participants. However, if one participant's identified career interest is restaurant work and the other participant wishes to work in a medical setting, documentation must show visits to the specific type of business for each participant.

Service Limits

Activities will be authorized for a maximum of 120 standard units in a service year for individual job assessment, discovery and development, and 20 standard units in a service year for group employment job assessment, discovery and development. A standard unit of service in job assessment, discovery, and development is 6 or more hours per day.

Authorization of Services

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

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

Job Assessment

Job assessment is the evaluation of a participant's skills and interests, and consists of one or more of the following activities:

- Vocational assessments to determine a person's career interests.
- Job analysis.

- Community-based situational assessments.
- Facility-based situational assessments.
- Participant profile.
- Placement plan.
- Assisting with personal care in activities of daily living.

Work activity training and work hardening skills training are prevocational services. Job assessment will not be authorized for services that prepare a participant for paid or unpaid employment in the community. This includes teaching concepts such as compliance, attendance, task completion, problem-solving and safety that are associated with performing compensated work, as well as, activities aimed at a generalized outcome.

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

Documentation Requirements

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

- Completed vocational assessment.
- Completed job analysis.
- Notes from community-based/facility-based situational assessments.
- Participant profile.
- Placement plan.

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

- The objectives and time lines outlined in the ISP were met timely;

- Identification in the document(s) of basic guidelines a job would need to meet. These guidelines must include, but are not limited to:
    - Specific career interest(s) are identified;
    - Maximum hours per week participant will consider working;
    - Minimum rate of pay participant will accept;
    - Benefits participant receives that might impact earnings, in particular SSI and/or SSDI;
    - Times of day participant will consider working;
    - Areas of town, city or parish(s) participant will consider working;
    - Transportation currently available to participant;
    - Current work strengths/skills that will help participant obtain job of his/her choosing;
    - Current barriers to participant obtaining job of his/her choosing; and
    - If group employment is the career outcome, the staff ratio needed to support the participant.

Job assessment activities for individual/self-employment/microenterprise will be authorized for a maximum of 120 standard units in a service year. Job assessment activities for group employment will be authorized for a maximum of 20 standard units in a service year. Utilization of job assessment units will be counted towards the total available units for job assessment, discovery and development for a service year. Therefore, if 120 (individual job/self-employment/microenterprise) or 20 (group employment) standard units are utilized in a service year, job discovery and development could not begin until the next service year. If all available units in job assessment, discovery and development are used only for job assessment for a participant in one service year, only job discovery and development activities and not job assessment will be authorized for the next service year.

Job Discovery and Development

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

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

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

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

The participant may or may not be present during job discovery and development activities. If the participant is not present, a signed and dated confidentiality release form must be in the participant's record in his/her native language indicating that the participant has approved contacts, meetings, education or training to occur in his/her absence.

Documentation Requirements

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

- All objectives and time lines related to job discovery and development outlined in the ISP were met timely. If changes were made, the revised ISP and new signature page with dates must be attached;
- Date, time, names and addresses of companies contacted and method of contact (e.g. in-person, by phone, letter, e-mail or through employer's website);
- Job restructuring activities, including meetings specific to an identified position in a community business including date, time, and names and job titles of community business staff in attendance. If meeting(s) occurred, meeting minutes must be submitted;
- Community business education and/or trainings specific to an identified job in a community business, including date, time, names and job titles of community business staff in attendance, and content of education and/or training session(s);

- Job accommodation, travel training, and any other employment related activities specific to an identified job in a community business;
- Amount of time spent in discovery and development per day; and
- Confidentiality release forms in the participant's native language, if applicable, that he/she approved contacts, meetings, education or training to occur in his/her absence.

Rates for job discovery and development are paid per participant, not per group. Job discovery and development may be provided on one staff to multiple participant ratios. Documentation of job discovery and development must be specific to each participant regardless of staff to participant ratio.

Initial Job Support and Retention

Support to the participant on or off the job site by provider staff may be intensive or intermittent, and short-term or ongoing. Initial job support and retention consists of one or more of the following activities:

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

- The participant needing assistance with completing documentation required by the employer or by an agency providing benefits that are affected by work income, such as SSI.

- Communications with the participant by telephone, e-mail or fax that is necessary for the participant to maintain gainful employment.

- Meetings with the community employer without the participant present are limited to five days per service year; which are counted as part of the total maximum number of standard units available. Examples of when such a meeting might occur include, but are not limited to: explanation and/or demonstration of significant change in job duties which the employer feels may require re-training for the participant to remain successfully employed; or discussion of a behavioral issue that may adversely impact the participant's ability to remain successfully employed. If the participant is not present at a meeting with the community employer, the provider will be expected to have the following documentation available upon request of the support coordinator, OCDD/WSS or HSS staff:

  - Date, time, names of persons in attendance at meeting;

  - Location and method of meeting (i.e. face-to-face with employer, by phone, or internet/videoconference);

  - Reason for meeting without participant and results of meeting; and

  - Written documentation through applicable confidentiality release forms in the participant's native language that the participant approved contacts and/or meetings to occur in his/her absence.

- Transportation to or from a community business site by provider staff in a staff or provider-owned vehicle. However, the provider must produce documentation upon request of the support coordinator or OCDD/WSS or HSS staff that all other possible sources of transportation, including those incurring a charge or without charge, have been exhausted. Under no circumstances can a provider charge a participant, his/her responsible representative(s), family members or other support team members a separate transportation fee.

- The following activities are included for self-employment/microenterprise:

- Assisting the participant in acquisition of skills necessary for operation of the business including clerical, payroll, tax functions, and inventory tracking system;
- Assisting with interviewing, hiring or terminating employees;
- Assisting with communications with vendors and customers; and
- Assisting with all functions of business operations.

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

- The participant is paid the same wage as a regular employee of that provider, but at least minimum wage;
- There is a job description for the position that would be utilized by the provider for a person without a disability; and
- The participant is paid all benefits, including holidays, absentee and vacation time that other employees without disabilities would receive in a comparable position.

Initial job support and retention may be authorized for group employment in a provider-owned or leased facility when:

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

Examples of this include but are not limited to laundry/ironing services, restaurants and retail shops.

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

Service Limits

Individual job, microenterprise/self-employment or group employment initial job support and retention activities may be authorized for 240 standard units or more in a service year. Rates are paid per participant, not per group. A standard unit of service is one hour or more per day.

Post authorization for initial job support and retention for units above 240 standard units per CPOC year will be granted when the support coordinator receives and approves documentation generated by the community business or host company where the participant(s) perform job duties. Post authorization for excess units will occur after 240 standard units have been utilized. When a participant(s) perform job duties at more than one community business or host company, there must be documentation from each employer. Acceptable documentation for post authorization from community businesses or host companies for units in excess of 240 units per CPOC year are the following:

- Participant payroll records; or
- Statement signed by the employer or host company that the participant(s) is required to work in excess of 240 days per calendar year; or
- A formal agreement or contract signed by the employer and provider that outline the participant(s) and/or provider's responsibility to be present in excess of 240 days per CPOC year to accomplish a job task; and
- Progress notes or other documentation from the provider that show initial job support and retention activities occurred for 1 or more hours per day in excess of 240 standard units in the CPOC year.
- A written or oral statement from the provider will not be accepted for approval of post authorization for units in excess of 240 standard units per CPOC year.

Staffing Ratios

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

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

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

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

Provider Qualifications

Providers of Supported Employment services must meet the following requirements:

- Possess a certificate of compliance from Louisiana Rehabilitation Services as a Community Rehabilitation Provider;

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

Day Habilitation Services

Day habilitation is services provided on a regularly scheduled basis during normal daytime working hours that assist the participant to gain desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the participant an opportunity to contribute to his or her community. These participants receive ongoing supervision in order to maximize their use of community resources and increase their self-sufficiency. Services focus on enabling the participant to attain or maintain his/her maximum functional level and must be coordinated with any physical, occupational, speech or recreational therapies identified in the ISP. They may also serve to reinforce skills or lessons taught in other settings. Day habilitation includes assisting with personal care activities of daily living. Choice of this service and staff ratio needed to support the participant must be documented on the CPOC.

Day habilitation provides services in the following areas:

- Volunteer activities;
- Community inclusion; and
- Facility-based activities.

Place of Service

Day habilitation is provided in a setting separate from the participant's private residence. Activities and environments are structured and designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

Volunteer activities must follow the guidelines of the United States Fair Labor Standards Act of 1985 as amended and occur in a business or organization where people without disabilities typically volunteer. These activities may be done individually or in a group. Volunteer activities cannot occur in a provider-owned business or facility.

Community inclusion activities occur in any community setting. They are recreational in nature and cover a wide range of opportunities including but not limited to classes in swimming, horseback riding, and trips to museums, local historical sites, libraries, and fairs.

Facility-based activities that occur in a provider owned facility, are recreational, educational or clinical in nature and cover a wide range of opportunities. They include but are not limited to sensory motor development, social, communication and behavioral skills, crafts, computers, gardening, self-advocacy, music and art appreciation.

Exclusions

Work activity training and work hardening skills training are prevocational services. Day habilitation will not be authorized for services that prepare a participant for paid or unpaid employment in the community. This includes teaching concepts such as compliance, attendance, task completion, problem-solving and safety that are associated with performing compensated work, as well as, activities aimed at a generalized outcome.

Providers of Day Habilitation services are not required to provide meals for participants. Payment for any meals does not include a full nutritional regimen of 3 meals per day.

Participants receiving Day Habilitation services may also receive Prevocational or Supported Employment services, but these services cannot be billed in the same service day.

Employment related services begin when the participant arrives at the training site and the training activities begin.

Transportation

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

Staffing Ratios

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

- One staff to one participant;
- One staff to two to four participants; or
- One staff to five to eight participants.
- The maximum ratio for day habilitation is one staff to eight participants.

Service Limits

Day habilitation must be scheduled on the service plan for 1 or more days per week and may be prior authorized for 240 up to a maximum of 254 standard units of service in a CPOC year. A standard unit of service is 5 or more hours per day.

Day habilitation may be prior authorized for a maximum of 254 units in a CPOC year if the support coordinator determines through the assessment process and information from the support team that the participant has a need for more than 240 standard units per CPOC year. Prior authorization will be granted based on information including, but not limited to:

- Behavior plans that specify supports in excess of 240 days per CPOC year;
- Goals on the CPOC that require in excess of 240 standard units for the service year;
- Requests from the participant, family, support team members or providers for units in excess of 240 without programmatic justification that the participant will benefit from excess units will not qualify for prior authorization.
- The fact that a provider agency is open for more than 240 days per calendar year will not qualify for prior authorization of units in excess of 240 standard units per CPOC year.

Post authorization will be granted for a maximum of 254 standard units in a CPOC year when the support coordinator receives and approves attendance records from the provider showing the number of days the participant received services.

Authorization of Services

In order to receive prior authorization when Day Habilitation and Habilitation services are chosen in conjunction with one another, the provider must submit specific educational strategies and time lines for each service that will be used to achieve the goals and time lines as outlined on the CPOC on the ISP. This documentation must be submitted to the support coordinator within five (5) working days after receiving the completed CPOC. This process must occur regardless of whether the same provider is chosen by the participant for both services, or different providers are chosen for each service.

The support coordinator will:

- Facilitate development of a CPOC that specifies but does not duplicate the training, supports and staff ratio, and time lines for Day Habilitation and Habilitation services;
- Cross reference the CPOC and the provider(s) ISPs to ensure that no duplication of services will occur;
- Approve prior authorization; and
- Forward the approved provider(s) ISP to the OCDD/WSS Regional Office the same or next business day after completing the cross checks.

Provider Qualifications

Day habilitation providers must meet the following requirements:

- Be licensed as an Adult Day Care provider by the DHH;
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

Prevocational Services

Prevocational services are provided in a supervised facility-based setting operated through the provider agency where more than 25% of the participants are individuals with a developmental disability. Prevocational services prepare a participant for paid or unpaid employment in the community and include teaching concepts such as compliance, attendance, task completion, problem solving and safety that are associated with performing compensated work.

Prevocational services are not job task oriented but instead are aimed at a generalized result and are directed to habilitative rather than explicit employment objectives. These services are provided to persons not expected to join the general work force within one year of service initiation. It also includes assisting with personal care in activities of daily living.

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

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

Staffing Ratios

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

- One staff to one participant;
- One staff to two to four participants; or
- One staff to five to eight participants;
- The maximum ratio for prevocational services is one staff to eight participants.

Transportation

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

There must be documentation in the participant's file that this service is not available from programs funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act and those covered under the Medicaid State Plan.

Participants receiving Prevocational services may also receive Day Habilitation or Supported Employment services, but these services cannot be billed in the same service day.

There must be documentation in the participant's file that this service is not available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act (230 U.S.C. 1401) (16 and 71) and those covered under the State Plan.

Participants receiving Prevocational services may also receive Day Habilitation or Supported Employment services, but these services cannot be billed in the same service day.

Service Limits

Prevocational services must be scheduled on the service plan for 1 or more days per week and shall not exceed 240 standard units of service in a plan year with no exceptions. A standard unit of service is five or more hours per day.

Choice of this service and staff ratio needed to support the participant must be documented on the Comprehensive Plan of Care.

Provider Qualifications

Providers of Prevocational services must meet the following requirements:

- Be licensed as an Adult Day Care provider by the DHH and/or possess a certificate of compliance from Louisiana Rehabilitation Services as a Community Rehabilitation Provider;
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

Respite

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

Respite services may be preplanned on the CPOC. However, if a participant anticipates needing respite in the CPOC year, but does not know when this will occur; he/she and his/her responsible party(s) should receive an FOC of respite providers and interview these providers. In this manner, the participant and his/her responsible party(s) and the provider they choose will be familiar with each other. When a situation occurs during the CPOC year in which respite will be needed, a revision to the CPOC will be done by the support coordinator; and the participant will be able to access the service in a timely manner.

Exclusion

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

Service Limits

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

Provider Qualifications

Respite service providers must meet the following requirements:

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

Habilitation

Habilitation offers services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community settings. These services are educational in nature and focus on achieving a goal utilizing specific teaching strategies. Goals may cover a wide range of opportunities such as learning how to clean house, do laundry, wash dishes, grocery shop, bank, cook meals, shop for clothing and personal items, become involved in community recreational and leisure activities, do personal yard work, and utilize transportation to access community resources. Travel training to community sites other than supported employment, day habilitation, or prevocational sites where life activities take place is a Habilitation service.

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

This service is provided in the home or community with the participant's place of residence as the primary setting and includes necessary transportation. It is based on need with a specified number of hours weekly as outlined in the approved service plan. Habilitation services may be provided at any time of day or night on any day of the week as needed by the participant to achieve a specified goal. It may only be provided on a one staff to one participant ratio.

Service Exclusion

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

Authorization of Services

To receive prior authorization when Day Habilitation and Habilitation services are chosen in conjunction with one another, the provider must submit specific educational strategies and time lines for each service that will be used to achieve the goals and time lines as outlined on the CPOC on the ISP. This documentation must be submitted to the support coordinator within five (5) working days after receiving the completed CPOC. This process must occur regardless of whether the same provider is chosen by the participant for both services or different providers are chosen for each service.

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

The support coordinator will:

- Facilitate development of a CPOC that specifies but does not duplicate the training, supports and staff ratio, and time lines for Day Habilitation and Habilitation services;
- Cross reference the CPOC and the provider(s) ISP(s) to ensure that no duplication of services will occur;
- Approve prior authorization; and
- Forward the approved provider(s) ISP(s) to the OCDD/WSS Regional Office the same or next business day after completing the cross checks.

Service Limits

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

Provider Qualifications

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

- Be licensed as a respite care service provider and/or a personal care attendant service provider by the DHH;

  OR

- Be a licensed occupational therapist in the State of Louisiana, or a licensed Physical Therapist in the State of Louisiana *or* certified through the National Council for Therapeutic recreation as a Therapeutic Recreational Specialist and be an employee of an agency holding a personal care attendant and/or adult day care license through the DHH Health Standards Section;

Personal Emergency Response Systems

Personal Emergency Response System (PERS) is an electronic device connected to the participant's phone which enables a participant to secure help when necessary. The system is programmed to send a signal to the response center once a "help" button is activated. Trained professionals staff the response center.

The provider must install and support PERS equipment in compliance with all applicable federal, state, parish and local laws.

This service must be preauthorized and be in accordance with the service plan.
PERS services are limited to the rental of the device. The fee includes a one time installation charge, training the participant in usage of the equipment, and a monthly maintenance fee.

Provider Qualifications

Providers of PERS must meet manufacturer's specifications, response requirements, maintenance records, and enrollee education.

COMPREHENSIVE PLAN OF CARE

The comprehensive plan of care (CPOC) is developed using person-centered planning through a collaborative support team process. The support team is comprised of the participant, his/her responsible party(s), the support coordinator, the direct service provider(s), and other persons chosen by the participant.

The CPOC is not defined by a calendar, state, federal, or fiscal year. It is defined by a specific twelve month period which is called the service year. This year begins on the date the CPOC is approved and runs for a twelve month period, e.g. July 1, 2006 through June 30, 2007. If the CPOC is amended during the service year, the original start and end date do not change.

The role of the participant and his/her responsible party(s) in the CPOC process is to:

- Facilitate the support team in planning;
- Abide by all rights and responsibilities outlined in OCDD/WSS-RF-02-047REQ;
- Provide medical, physical, psycho-social and behavioral information and documentation as requested by the support coordinator;
- Provide socialization/recreational information and documentation, including relationships that are important to the participant and the social environment of the participant as requested by the support coordinator;
- Provide information regarding the participant's everyday life;
- Assist in identification of natural supports;
- Provide information and documentation on financial resources;
- Provide educational and vocational information and documentation;
- Provide information on the current status of housing and the physical environment of the participant;
- Provide information about previously successful and non-successful strategies to assist the participant in achieving his/her desired personal outcomes; and
- Provide any other information relevant to understanding the supports and services needed by the participant to achieve his/her personal outcomes.

The role of the support coordinator in the CPOC process is to:

- Assist the participant to lead his/her CPOC planning process;
- Identify areas where a professional evaluation may be necessary in order to determine appropriate services or interventions to be included in the CPOC;
- Assist the participant and his/her responsible party(s) in accessing services needed to complete Form 90-L LOC;
- Assist the participant and his/her responsible party(s) in obtaining original documents or certified copies proving United States citizenship and identity;
- Ensure that all CPOC team members that the participant wishes to participate in the process are informed of meetings in a timely manner;
- Ensure that all non-funded and funded services and supports on the CPOC meet the participant's health and welfare needs as determined by assessments and personal interviews;
- Explain all waiver services to the participant and team members and ensure that the CPOC is completed in required time lines;
- Ensure that the participant, his/her responsible party(s) and support team members understand that the CPOC is a flexible document which must be updated annually. The participant can request a support team meeting at any time during a service year. This meeting might trigger a revision to the existing CPOC;
- Assist the participant in re-convening the support team and facilitating the planning process if additional support team meetings are requested during a service year; and
- Ensure that the completed CPOC containing dated signatures of all support team members is submitted to the appropriate OCDD/WSS regional office no later than thirty-five (35) days after the support coordination agency is chosen by the participant or no later than thirty-five (35) days prior to the expiration of the annual CPOC.

The role of the direct service provider(s) in the CPOC process is to:

- Provide information about services the agency offers to participants and team members;

- Develop an individualized service plan (ISP) based on the information in the completed CPOC; and

- Agree to provide approved waiver services based on the needs of the participant as determined during the CPOC planning process.

The role of other support team members (i.e. those team members other than the participant, his/her responsible party(s), support coordinator and direct service provider) invited to participate in the CPOC planning process by the participant is to:

- Provide medical, physical, psycho-social and behavioral information and documentation as requested by the support coordinator;

- Provide socialization/recreational information and documentation, including relationships that are important to the participant and the social environment of the participant as requested by the support coordinator;

- Provide information regarding the participant's everyday life;

- Assist in identification of natural supports;

- Provide information and documentation on financial resources;

- Provide educational and vocational information and documentation;

- Provide information on the current status of housing and the physical environment of the participant;

- Provide information about previously successful and non-successful strategies to assist the participant in achieving his/her desired personal outcomes; and

- Provide any other information relevant to understanding the supports and services needed by the participant to achieve his/her personal outcomes.

The role of the OCDD/WSS regional office in the CPOC process is to:

- Conduct a pre-certification visit in a place chosen by the participant and/or his/her responsible party no later than ten (10) days after receipt of the completed CPOC from the support coordination agency. The pre-certification visit may take place in the participant's or someone else's place of residence, the workplace or facility, or any other place in the community.

- Ensure that the participant and his/her responsible party(s) were satisfied with the planning process, including the amount of their involvement;

- Ensure that the participant and his/her responsible party(s) understand the rights and responsibilities outlined in OCDD/WSS-RF-02-047REQ and in particular know how to file a complaint or request an appeal; and

- Answer any questions that the participant and his/her responsible party(s) may have about the waiver or the CPOC planning process.

AUTHORIZATION OF SERVICES

Prior and Post Authorization for Billing

Prior Authorization

Once an initial or annual CPOC has been completed and any applicable prior-authorization documents have been reviewed by the support coordinator, the plan is forwarded to the OCDD/WSS Regional Office for final review. Only services in the approved CPOC will be prior authorized.

The OCDD/WSS Regional Office checks for:

- An appropriate and complete Request for Medicaid Eligibility Determination (Level of Care) Form 90-L;
- A completed initialed Freedom of Choice list (by the participant or his/her responsible representatives);
- Copies of documents proving citizenship and identity;
- A CPOC signed and dated by all support team members; and
- Any applicable documents necessary for prior authorization of a service (e.g. portion of ISP with dated signatures of support team members).

Initial CPOCs

If all documents are complete and correct, the OCDD/WSS Regional Office will issue a "Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification" Form 142 and forward it to the Medicaid Parish Office for Medicaid eligibility approval.

The parish office will issue "Department of Health and Hospitals Medicaid Program Adequate Notice of Home and Community-Based Services (Waiver) Decision" Form 18-W to the participant, support coordinator and the OCDD/WSS Regional Office. This form notifies the participant that he/she has or has not been approved for waiver services and gives appeal rights notification instructions. If approved for services, the OCDD Regional office issues a "Notification of Admission, Status Change or Decertification/Discharge for HCBS Waiver" Form 148-W and a "Louisiana's Medicaid Program Nursing Facility & Waiver Services Admission & Change" Form 51-NH. The date on the 51-NH is the vendor payment begin date.

Annual CPOCs

Annual CPOCs must be complete and have complete Request for Medicaid Eligibility Determination (Level of Care) Form 90-L and any applicable documents necessary for prior authorization of a service (e.g. portion of the IPS with dated signatures of support team members).

Once all necessary documents have been received and verified by the OCDD/WSS Regional Office the state's data contractor is sent information that triggers the prior authorization for services. Authorizations are issued quarterly directly to the provider and end on the CPOC end date. The OCDD/WSS Regional Office has the final responsibility for prior authorization of all services in this waiver.

Post Authorization

To receive post authorization, a provider must enter the information in the Louisiana System Tracking (LAST) of the Medicaid Management Information System (MMIS). The state's data contractor checks LAST against the PA and releases the units of service. Once the post authorization is granted, the provider may bill the fiscal intermediary for the appropriate number of service units.

Timely Payment

In order to ensure timely payment of claims, the service provider must:

- Ensure all required data provided to the support coordinator is correct;
- Immediately check prior authorizations to see that all authorized services match the approved services in the CPOC. Contact the support coordinator to correct any errors in prior authorization. The OCDD/WSS Regional Office must approve all changes. After correction and approval the forms must go through the authorization process again;
- Review the direct service worker timesheet to ensure the services delivered are in the OCDD/WSS approved CPOC and/or revisions;
- Bill only the amount of services that were documented as provided (as evidenced by the timesheets and case record notes) and are within the approved services in the CPOC;
- Bill within the correct span dates using the authorization number, provider number and participant number as indicated on the authorization;
- Reconcile all remittance advices issued by the FI with each payment; and
- Check each participant billing to see that payment was issued correctly.

Providers have one-year from the date of service to file a claim. This means that the service provider has up to one year to bill for prior authorized services delivered in accordance with the approved CPOC.

CHANGING DIRECT SERVICE PROVIDERS

The participant may change direct service providers once every service authorization quarter (3 months) with the effective date being the beginning of the following quarter or for good cause at any time as approved by the OCDD/WSS regional office.

Good cause is defined as:

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

A participant and/or responsible party(s) who want to change direct service provider(s) will be responsible for contacting his/her support coordinator.

The support coordinator will assist the participant and/or responsible party(s) in facilitating a team meeting involving the current direct service provider(s). This meeting should address the participant's reasons for wanting to terminate the provider(s). Whenever possible, the current direct service provider should have the opportunity to submit revisions to the ISP with specific time lines not to exceed thirty (30) days to attempt to meet the needs of the participant.

If the revised thirty (30) day ISP and time lines agreed to by the team cannot be met; the participant and/or responsible party(s) refuse a team meeting; or the support coordinator and OCDD/WSS regional office determine that a meeting is not possible or appropriate, the support coordinator will:

- Provide the participant and his/her responsible party(s) with the current FOC list of service providers.
- Assist the participant and his/her responsible party(s) in completing the FOC and release of information form.
- Assist the participant and his/her responsible party(s) in informing the current direct service provider agency of the impending transfer.

- Obtain the case record from the releasing provider which must include:
    - The most current six months of progress notes. If the participant has received services from the provider for less than six months, all progress notes from date of admission;
    - Written documentation of services provided;
    - Most current ISP;
    - Records that track participant's progress towards goals and objectives in ISP, including standardized vocational assessments and/or notes regarding community or facility-based work assessments;
    - If a stated goal and objective in the most current ISP is obtaining competitive work in the community, records of the job assessment, discovery and development activities that occurred;
    - Copies of current and past behavior management plans;
    - Documentation of amount of authorized services remaining in the CPOC, including applicable time sheets; and
    - Documentation of exit interview.

NOTE: The new service provider must bear the cost of copying which cannot exceed the community's competitive copying rate.

- Forward copies to the new service provider of:
    - Most current CPOC;
    - Current assessments on which CPOC is based;
    - Number of services used in the calendar year;
    - Records from the previous service provider; and
    - All other waiver documents necessary for the new service provider to begin providing supports and services.

- Transfers must be made seven (7) days prior to the end of the service authorization quarter in order to coordinate services and billing, unless the OCDD/WSS regional office waives this requirement in writing due to good cause.

Prior Authorization for New Service Providers

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

OCDD/WSS or its agent will not backdate the new PA period to the first day of the first full calendar month in which the FOC and transfer of records are completed. If the new provider receives the records and admits a participant in the middle of a month, the new provider cannot bill for services until the first day of the next month.

DIRECT SERVICE PROVIDER RESPONSIBILITIES

The direct service provider's involvement begins upon notification from the support coordination agency that the participant has chosen their agency to deliver Supports Waiver services. A list of providers will be furnished by the support coordination agency.

Waiver services are based on the needs of the participant. The direct service provider will be paid only for services based on the approved CPOC. Informal incidental learning opportunities are expected to be provided and documented on progress notes as part of all paid services.

Waiver services are provided as a supplement to Medicaid State Plan services and natural supports. All natural supports, available community resources, and applicable Medicaid State Plan services must be exhausted prior to utilization of waiver funding. This waiver is not a lifetime entitlement or fixed annual allocation.

Supports and services are planned according to the needs of the participant, not for the convenience of the provider of direct services. Changes in the CPOC will not be made solely on the request of a provider.

All waiver services must be prior and post authorized (PA). Until the provider receives an approved PA, no services can be reimbursed. In the event that reimbursement is received without an approved PA, the amount paid will be recouped.

The direct service provider is responsible for:

- Ensuring that an appropriate representative from the agency attends the CPOC planning meeting and is an active participant in the team meeting. An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the participant's service delivery. This person may be a program manager, a direct service professional who works with/will work with the participant, the executive director or designee.

- Communicating and working with support coordinators and other support team members to achieve participants' personal outcomes.

- Ensuring that participant's emergency contact information and list of medications are kept current.

- Informing the support coordinator by telephone or e-mail a minimum of ten business days prior to the expiration of any time lines in individual service plan (ISP) that will not be met.

- Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or time lines in the ISP will not meet the participant's needs, but no later than ten business days prior to the expiration of any time lines in an ISP that cannot be met.

- Ensuring that all support team members sign and date any revisions to ISPs indicating agreement with changes to the goals, objectives or time lines.

- Providing the support coordination agency with requested written documentation including, but not limited to:

    - Completed, signed and dated ISP.

    - Evidence that the participant has applied for and exhausted all job assessment, discovery and development services available through the Louisiana Rehabilitation Services or the Individuals with Disabilities Education Act if the participant is still attending high school.

    - Records that track participant's progress towards goals and objectives in ISP, including standardized vocational assessments and/or notes regarding community or facility-based work assessments.

    - Progress notes.

    - Participant attendance and payroll records.

    - Written grievances or complaints filed by participant.

    - Critical or other incident reports involving the participant.

    - Entrance and exit interview documentation.

- Ensuring that the Freedom of Choice (FOC) list has correct agency mailing and physical addresses, telephone and fax numbers, e-mail address, name of executive director, and all current services being provided.

- Maintaining all required licenses, certification, Standards for Participation and/or agreements required to be an enrolled provider of Medicaid waiver services.

- Ensuring that all staff receives training within established time lines and as specified in licenses, certifications, Standards for Participation and/or agreements.

- Explaining to the participant and/or responsible party in his/her native language the agency's participant rights and responsibilities, release of information, grievance/complaint procedures and confidentiality policy. When possible, the participant and his/her responsible party(s) should sign and date and receive copies of such documents.

- Maintaining confidentiality of participant's records and information based on Medicaid and HIPAA requirements.

- Assuring that participants are free to make a choice of providers without undue influence. Therefore, service providers who have been appointed to be the participant's legal representative may not provide services to that participant.

- Ensuring that relatives providing Respite or Habilitation services to a waiver participant meet the following criteria:

    - Are not the legally responsible parties: foster parent, tutor, curator, legal guardians or participant's spouse;

    - Do not live at the participant's residence;

    - Are an employee of the participant's enrolled waiver service provider of choice; and

    - Meet all training and criteria as required by the waiver service provider, OCDD/WSS and the Bureau of Health Services Financing.

Individualized Service Plans

The direct service provider must develop an individualized service plan (ISP) for all waiver services to meet the participant's needs based upon the goal(s) identified in the OCDD/WSS approved CPOC.

The ISP should follow the CPOC in being person-centered and focusing on the participant's desired outcomes. The ISP must be reviewed and updated as necessary to comply with specified goals, objectives and time lines.

The ISP must include the following elements:

- Specific goal(s) that match the goal(s) outlined in the CPOC;

- Measurable objectives with time lines in order to meet the specified goals;
- Strategies to meet the objectives;
- Identification of the direct service provider staff and any other support team members who will be involved in implementing the strategies;
- The method that will be used to document and measure the implementation of specified goals and objectives; and
- Dated signatures of the participant, his/her responsible party(s) and all support team members indicating agreement with goals and objectives of the ISP.

The portion of the ISP that details the goals, objectives, strategies and time lines for the following services must be submitted to the participant's support coordinator to be included with the CPOC in order for the direct service provider to receive prior authorization for these services: job assessment, discovery and development activities; and day habilitation and habilitation, when these services are chosen in conjunction with one another.

For post authorization for job assessment, discovery and development, specific documents must be furnished to the participant's support coordinator that provide proof that the goals, objectives, strategies and time lines on the ISP were met. These documents are to be included with the CPOC for the direct service provider to receive post authorization. Details about the required documentation can be found in Section 43.7 Services.

QUALITY MANAGEMENT

The Centers for Medicare and Medicaid Services (CMS) require Home and Community-Based Services (HCBS) Waivers to include the quality management functions of discovery, remediation, and improvement in the following focus areas of program design:

- Participant access;
- Participant-centered service planning and delivery;
- Provider capacity and capabilities;
- Participant safeguards;
- Participant rights and responsibilities;
- Participant outcomes and satisfaction; and
- System performance.

In order to meet these requirements, quality management activities must be built into the processes and procedures performed at all levels of the services system including direct service provision. Everyone has a role to play in assuring that participants receive quality supports and services that meet their needs while assuring their health and safety.

A person or team of persons within the agency shall be responsible for coordinating the agency's quality management activities. Additional staff and stakeholders may have roles and responsibilities (e.g., the responsibility of direct support staff to report critical incidents or the responsibility of the participant or family member to report if a direct service worker fails to show up at his or her assigned time). These roles and responsibilities should be clearly communicated to staff and stakeholders so that each person knows what their role is in quality assurance activities and quality improvement initiatives.

The Quality Improvement Plan

Service providers must submit an initial and annual Quality Management and Improvement Plan to the OCDD/WSS Quality Assurance/Quality Enhancement Program Manager that includes internal mechanisms to monitor and measure performance, review findings and analyze and trend data, establish priorities, and develop strategies for remediation and improvement. The Quality Management and Improvement Plan includes, but is not limited to the following components:

- Designation of a staff person/team to coordinate the quality management activities of the agency and a description of the roles and responsibilities of staff and others related to the agency's quality management activities;
- Establishment, composition and role of a Quality Improvement Committee;
- Completion of a self-evaluation on at least an annual basis;
- Development and implementation strategies for the Quality Improvement Plan;
- The quality management roles and responsibilities of staff and others;
- The discovery methods that will be used, what types of data will be collected, and the methods for analyzing, tracking and trending data;
- Documentation of the progress achieved on attaining the goals from the preceding year's Quality Improvement Plan including, but not limited to:
    - Preceding year's goals;
    - Strategies implemented to achieve goals;
    - Effectiveness of strategies utilized;
    - Improved performance and benchmarks reached; and
    - Goals that have to be continued in the next plan with specific reasons for need for continuation and strategies to improve performance for each goal, including specific actions to be taken; time lines; revised quality indicator(s) and revised benchmark(s).

The Quality Improvement Committee

Each agency is required to have a Quality Improvement Committee composed of staff and stakeholders. The committee should meet quarterly at a minimum and be involved in identifying quality indicators, reviewing quality data and reports, and developing remediation and improvement goals and strategies.

Activities related to discovery result in data and information from which quality indicators are selected. The data may include, but is not limited to:

- Participant and family survey data;

- Staff survey data;
- Focus group data;
- Critical incidents data;
- Complaint data;
- Internal provider monitoring data including the provider self-evaluation;
- Participant personal outcome data;
- Licensing survey results; and
- Other data (e.g., staff turnover).

Development of quality indicators is a mechanism for utilizing an abundance of data to focus on a smaller set of criteria thought to be indicative of overall agency performance in a broad array of areas. Examples of potential quality indicators include, but are not limited to:

- Percentage of participants reporting that they are doing the type of work that they want to do;
- Average hourly earnings of participants;
- Percentage of records reviewed by the agency which meet documentation requirements; and
- Percentage of complaints that are resolved to the satisfaction of the participant/family.

Data should be analyzed to assist the agency and the Quality Improvement Committee to evaluate if basic assurances are being adequately met (e.g., licensing requirements and requirements of other relevant statutes, rules, program policies and procedures) and if quality improvement strategies are effective in addressing quality improvement goals. Quality improvement goals include, but are not limited to:

- Improved participant satisfaction;
- Improved support team member satisfaction with participant supports and services;
- Improved community inclusion of participants; and

- Improved health of participants.

Quality improvement involves the review of quality data, identification of priorities for improvement, and development of a Quality Improvement Plan that includes implementation of strategies and actions designed to improve performance on quality indicators of interest.

Quality improvement may take many months, depending on the nature of the goal and strategies. For example, a quality improvement goal of improved community inclusion may involve identifying a participant's interests, identifying community inclusion opportunities, matching him/her with community inclusion opportunities based on interests and measuring his/her satisfaction concerning participating and being included in the community.

Generally, Quality Improvement Plans have between three to six quality improvement goals with one or more strategies for each goal. However, at times an agency's plan may have fewer than three or more than six quality improvement goals, depending on what the data is indicating and the priorities of the agency.

If strategies prove ineffective, the committee should use brainstorming and problem solving to design more effective strategies to improve performance on the goal. As goals are reached and performance on the goal is sustained, the goal that has been achieved is replaced with a new goal to improve a different area of performance.

The Quality Improvement Plan should be dynamic and ongoing. Sometimes a particular goal may continue from one year to the next, but the Quality Improvement Plan should not be identical from one year to the next. The plan should be constantly evaluated and updated as goals and strategies are modified or achieved and as new goals are identified.

The Provider Self-Evaluation

The Provider Self-Evaluation is a self-monitoring tool designed to assist agencies in evaluating their performance. The purpose of the self-evaluation is to assess the presence of required documentation, participation satisfaction, and the presence of personal outcomes as defined by a participant in a representative sample of individuals served by the support coordination or service provider agency. The self-evaluation includes, but is not be limited to:

- Interviews with participants in a representative sample;
- Interviews with others who know the participant best (family, friends, support staff professionals, other members of the person's network of supports);
- A review of the case records of the participants in the representative sample; and

- A review of the agency's compliance with licensing and program standards.

Findings of the self-evaluation must indicate the presence of corrective action steps and progress to eliminate the problem area(s).

An annual self-evaluation report must be submitted to the OCDD/WSS Quality Assurance/Quality Enhancement Program Manager no later than thirty (30) days after the anniversary date of the previous Quality Management and Improvement Plan and must include, but is not limited to:

- An assessment of the presence of required case record documentation in the representative sample;
- An assessment of the overall satisfaction and satisfaction with various aspects of the participant's quality of life and quality of services for the representative sample;
- A description of the personal outcomes defined and prioritized by each individual in the representative sample and an assessment of the agency's performance in assisting participants to achieve their personal outcomes;
- A description of any internal corrective action steps and progress to eliminate the problem area(s); and
- A written request or plan to acquire any needed technical assistance, training, and/or support.

The self-evaluation is one of method of discovery. The data from this survey may be used to develop quality indicators and quality improvement goals. However, remediation on the problems area(s) (e.g., provider is substantially out of compliance with regulations or policies; the health and welfare of participants is in jeopardy) should be immediately addressed with a corrective action plan that is incorporated into the overall Quality Improvement Plan.

GENERAL RECORD KEEPING

In accordance with Standards for Participation Rule, published, September 20, 2003, in the *Louisiana Register,* the service provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as defined by Centers for Medicare and Medicaid Services regarding records and documentation. The service provider shall maintain all records required by the Bureau of Health Services Financing (BHSF), Health Standards Section (HSS) and the Office for Citizens with Developmental Disabilities Wavier Supports and Services (OCDD/WSS).

Failure to comply with record keeping requirements will result in one or more of the following:

- Recoupments;
- Loss of enrollment; and/or
- Referral to BHSF Program Integrity Section.

Participant Records

Service provider agencies must each have a separate written record for each participant. Documentation of services offered to individual waiver participants for the purposes of continuity of care and support and monitoring of progress toward outcomes and services received must be included in each participant's record. This documentation must include an on-going list of activities and/or services undertaken on behalf of the participant.

Participant records and location of documents within the record must be consistent among all records. Records must be appropriately maintained so that current material can be located in the record.

All entries and forms completed by staff in participant records must be in ink, legible and include at a minimum:

- The name of the person making the entry;
- A legible signature or initials of the person making the entry;
- A functional title of the person making the entry;
- The full date, including month, day and year of documentation; and

- Documentation that entries were reviewed by the supervisor, if required.

Correction in a participant's record may only be made by the legal method of drawing a line through the incorrect information, writing "error" by it and initialing the correction in ink. **Correction fluid must never be used in a participant's records.**

OCDD/WSS does not prescribe a specific format for documentation but must find all of the components outlined above in a participant's active record. However each participant record must contain, at a minimum the documents identified in the DHH Home and Community-Based Waiver Services Standards for Participation and, in addition, for the Supports Waiver participants the following:

- Identifying current demographic information on the participant recorded on a standardized form that includes, at a minimum:
  - Name;
  - Home address;
  - Home telephone number;
  - Date of birth;
  - Social Security number;
  - Medicaid/Medicare and other insurance card numbers;
  - Name and number of primary care physician;
  - Name and number of preferred hospital;
  - Name and phone number of closest living relative or person to contact in case of emergency;
  - Marital status;
  - Sex;
  - Race or ethnic origin (optional);
  - Preferred religion (optional);
  - Name and address of current employment, school, or day program, as appropriate;
  - List of current medications;
  - Any threatening medical conditions including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or known allergies;
  - Primary and secondary disability;

- Date of initial contact;
- Court and/or legal status, if applicable including relevant legal documents;
- Names, addresses, and telephone numbers of other team members, including other providers and support coordinator involved with the participant's CPOC;
- Date information was entered or updated in record; and
- Signature or initials of staff member entering the information.

- Documentation of the need for ongoing services;
- Medicaid eligibility information;
- A copy of the Freedom of Choice Form for providers, participant rights and responsibilities, confidentiality, and grievance procedures, etc., signed by the participant;
- Approved CPOC with revisions;
- Complete ISP as specified in the Section 43.6, Services of this manual with documentation that show service changes warranted by CPOC revisions occurred within five working days of receiving a copy of the approved CPOC or revision(s) signed and dated by the participant and copies of all pertinent correspondence;
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified below;
- Critical Incident Reports;
- Formal grievances filed by the participant;
- Written documentation of day-to-day activities of the participant that addresses his/her ISP goals. This may be in checklist form;

  Progress notes that are completed a minimum of one time each month and must be of sufficient content to reflect descriptions of activities, procedures, and incidents; provide an overview of services rendered; and show progress toward outcomes and goals. Examples of general terms, that when used alone are not sufficient and do not reflect adequate content for progress notes are: "Called the participant(s)"; or "Supported participant(s)"; or "Assisted participant(s)"; or "Participant is doing fine"; or "Participant had a good/bad day". Checklists alone are not adequate documentation for progress notes;

- Attendance records;

- Eligibility records;
- A copy of the behavior support plan, if one is required;
- Documentation of all interventions used to ensure the participant's health, safety and welfare. Interventions may include, but are not limited to, medical, consultations and environmental and adaptive interventions;
- Reason for case closure and any agreements with the participant at closure;
- Records that reflect the most current utilization of services up to six months. Records older than six (6) months may be kept in storage files or folders, but must be available for review. At the start of each new CPOC year the active record must contain a minimum of 6 months of the above documentation;
- For participants with less than six months of services, all documentation must be in their record;
- Any additional documentation required for other services identified in service definition section;
- A sign-out sheet with the signature and date of the people who viewed the record in a location other than the room in which the record is stored or made copies of portions of the record to take outside the building where the record is stored; and
- Any other pertinent documents.

In addition, if the provider transports the participant at any time a *separate* record for each participant transported must be in the vehicle(s) when the participant is transported. At a minimum, this individual record should contain the participant's name/phone/address; emergency contacts; social security number; Medicaid and/or Medicare insurance number; number of any other insurance coverage; current medications; current physician name/phone/address; preferred hospital; preferred religion (if stated); and current medical conditions including allergies. If a number of participants are being transported, records may be kept together.

Participant's transportation records must be returned to a secure, locked location after transportation has been provided and not left in a vehicle

Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, DHH Standards for Participation and Medicaid enrollment agreements.

Retention of Records

Service providers must retain administrative, personnel, and participant records for whichever of the following time frames is longer:

- Five years from the date of the last payment; *or*
- Until records are audited, and there is written documentation from the auditor that all audit questions have been answered to the satisfaction of all parties involved.

Note: ***Upon agency closure, all records must be maintained according to applicable laws, regulations and the above record retention requirements and copies of the required documents transferred to the new agency. The new service provider agency must bear the cost of copying which cannot exceed the community's competitive copying rate.***

Confidentiality and Protection of Records

Both administrative and participant records must be secured against loss, tampering, destruction or unauthorized use. Service providers must comply with the confidentiality regulations as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Employees of the service provider agency must not disclose or knowingly permit the disclosure of any information concerning the agency, the participants or their families directly or indirectly, to any unauthorized person. Service providers must safeguard the confidentiality of any information that might identify the participants or their families. The wrongful disclosure of such information may result in the imposition by DHH of whatever sanctions are available pursuant to Medicaid certification authority or the imposition of a monetary fine and/or imprisonment by the United States Government pursuant to HIPAA. Information concerning a participant, a participant's responsible representatives or a participant's family members may be released only under the following conditions:

- By court order; or
- Upon written informed consent for release of information from the participant, a copy of information in a participant's case record may be released to the participant or the participant's responsible representative(s); *or*

- If the participant has been declared legally incompetent, his/her legal representative must provide written consent for the release of information.

The service provider may deny access to the record if a licensed health care professional, in the exercise of professional judgment, determines that the access requested is reasonably likely to endanger the life or physical safety of the participant or another person. This determination must be documented in writing.

The service provider may charge a reasonable fee to the participant or his/her legal representative(s) for the cost of copying which cannot exceed the community's competitive copying rate for providing the above records to the participant.

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

Location of Records

Participant records must be located at the site where the participant receives services. In the case of supported employment services, the records must be maintained at the office in the region where the participant lives.

Under no circumstances can a service agency allow any staff, including management, to take a participant's entire case record from the location where it is housed. Copies of portions of case records that are specific and necessary to ensure the health and safety of the participant may be taken off site to a CPOC or ISP meeting.

Review by State and Federal Agencies

Service providers must make all administrative, personnel, and participant records available to BHSF, HSS, OCDD/WSS and appropriate state and federal personnel at all times of office operation.

Monitoring of Records

The DHH has instituted a procedure in which the BHSF/HSS will provide management, direction, and supervision of enrolled providers of waiver services.

Services records are monitored to assure compliance with DHH policy as well as applicable state and federal regulations by HSS, OCDD/WSS and support coordinators.

DHH Monitoring of Records

DHH will conduct survey reviews of each provider of waiver services. These reviews are conducted to monitor the provider's compliance with DHH licensing or certification requirements, Standards for Participation, and to evaluate the continued capacity for provision of appropriate, quality-driven services, including health and safety to waiver participants.

In addition to reviewing licensing and enrollments, an annual monitoring of 5% of Supports Waiver participants plus certain participants identified as high risk is conducted. This monitoring focuses on the quality of services and supports provided by the support coordination agency and direct service provider.

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

- Participant's health, safety, and welfare;
- Services provided in accordance with approved CPOC;
- Participant's access to needed services identified in the service plan;
- Quality of assessment and service planning;
- Appropriateness of services provided including content, intensity, frequency and participant input and satisfaction;
- The presence of the personal outcomes as defined and prioritized by the participant/guardian;
- Internal quality assurance/quality improvement activities;
- Compliance with DHH Standards for Participation for Medicaid Home and Community-Based Waiver Service providers;
- Critical incident investigations;
- Mortality case reviews;
- Consumer satisfaction interviews; and
- Provider Quality Management and Improvement Plans.

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

Support Coordination Monitoring of Records

Types of record reviews conducted by support coordinators include the following:

- Review of participant's active case record to evaluate the quality of services and supports delivered to waiver participants and to assure services are rendered according to the participant's CPOC. The primary focus is placed on the outcomes to the waiver participant;
- Review to ensure that the activities of the provider agency are associated with the appropriate services of intake, ongoing assessment, planning (development of the CPOC), transition/closure, and that these activities are effective in assisting the participant to attain or maintain the desired personal outcomes;
- Reviews of participant's ISP;
- Review of documentation to ensure that the services reimbursed were:
    - Identified and relate to personal outcomes on the CPOC;
    - Provided;
    - Documented properly; and
    - Appropriate in terms of frequency and intensity.

ABUSE AND NEGLECT

Critical events or incidents that are required to be reported for review and follow-up action by the appropriate authority are:

- Abuse: The infliction of physical or mental injury on a participant by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (Louisiana Revised Statutes 14:403.2).

- Exploitation: The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of an aged person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (Louisiana Revised Statutes 14:403.2).

- Extortion: The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (Louisiana Revised Statutes 14:403.2).

- Neglect: The failure, by a care giver responsible for an adult's care or by other parties, or by the adult participant's action or inaction to provide the proper or necessary support or medical, surgical, or any other care necessary for his well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (Louisiana Revised Statutes. 14:403.2).

- Physical Injury: An injury that requires more than first aid and/or emergency room visits or hospitalization. (OCDD/WSS Critical Incident Report Instructions; OCDD/WSS PF-03-019).

- Sensitive Situation: A situation in which the police or fire department is called for domestic violence, drug involvement, household fire, etc. that may be made known to the public by way of local news stations or papers or a breech of confidentiality between the provider, staff or case manager and/or participant. (OCDD/WSS Critical Incident Report Instructions; OCDD/WSS PF-03-019).

- Restraints: Unauthorized use of chemical, mechanical or physical restraints used to restrain a person against their will or rights. (OCDD/WSS Critical Incident Report Instructions; OCDD/WSS PF-03-019).

- Missing: A participant is reported missing, has eloped or his whereabouts are unknown (OCDD/WSS Critical Incident Report Instructions; OCDD/WSS PF-03-019).

- Illness: Any illness of a participant. (OCDD/WSS Critical Incident Report Instructions; OCDD/WSS PF-03-019).

- Death: Any death of a participant. (OCDD/WSS Critical Incident Report Instructions; OCDD/WSS PF-03-019).

In accordance with Louisiana Revised Statutes 40:2009.13 B reporting criteria, "any person who has knowledge that a state law, minimum standard, rule, regulation, plan of correction promulgated by the department, or any federal certification rule pertaining to a health care provider has been violated, or who otherwise has knowledge that a consumer has not been receiving care and treatment to which he is entitled under state or federal laws, may submit a report regarding such matter to the department. " Further, "Any person having cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, exploitation or extortion shall report to the adult protection agency or to law enforcement." (R.S 14.403.2 C and D)

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

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

Service providers are required to take mandatory actions when a participant is in immediate jeopardy. All licensed and enrolled providers of waiver services are required to abide by the following minimum necessary actions in the event of immediate jeopardy or a critical incident:

- Call 911 for emergency help or the local law enforcement agency;

- For incidents involving abuse, neglect, extortion or exploitation the report is sent to the appropriate protective services agency; i.e. Bureau of Protective Services (BPS): (800) 898-4910 for participants ages 18 through 59, Office of Community Services (OCS) www.dss.state.la.us for specific contact numbers for participants ages birth through 17, or Elderly Protective Services (EPS): (800)-259-4990 for participants 60 years of age or older;

- Initiate an internal investigation only for incidents that do not meet the definition for abuse/neglect/exploitation or extortion;

- Contact the OCDD/WSS State Office Critical Incident Manager and OCDD/WSS Regional Office within 2 hours, or 1st business day by phone or in writing; and

- The service provider shall also copy the support coordination agency on all critical events or incidents.

The OCDD/WSS Regional Office takes the lead in triaging critical events and incidents reported to them, beginning an investigation of those incidents that do not involve abuse, neglect, extortion or exploitation, and referring those involving abuse, neglect, extortion or exploitation to the appropriate protective service agency. The OCDD/WSS State Office Critical Incident Manager reviews all critical events and incidents not involving abuse, neglect, extortion or exploitation or provider non-compliance, and works closely with the OCDD/WSS Regional Office as necessary on recommendations and resolution.

If a critical event or incident involving abuse, neglect, extortion or exploitation is called into the HSS complaint line they refer it to the appropriate protective services agency. If the report deals with another critical incident or event not in those categories, they may refer it to the OCDD/WSS State Critical Incident Program Manager for investigative action.

Regional OCDD/WSS offices are required to complete a preliminary report within 72 hours of the receipt of an initial incident report. Incident reports shall be completed by 30 calendar days from receipt of the initial report. If an incident cannot be resolved by the assigned date, an extension shall be requested by the regional supervisor to the OCDD/WSS State Office Critical Incident Manager.

Methods of reporting critical events and incidents include by written correspondence by fax, by telephone, or by a personal visit in accordance with Louisiana Revised Statutes 40:2009.13.

When OCDD/WSS suspects or identifies patterns of abusive or fraudulent Medicaid billing, the service provider will be referred to the Program Integrity Section of the Medicaid Program for investigation.

DHH has an agreement with the Attorney General's Office, which provides for the Attorney General's office to investigate Medicaid fraud. The Office of the Inspector General, Federal Bureau of Investigation (FBI), and Postal Inspectors also conduct investigations of Medicaid fraud.

DEFINITIONS

Active Participant: Agency personnel or support team members who provide supports that assist a participant in achieving his/her personal outcomes.

Activities of Daily Living: An individual's daily habits such as bathing, dressing and eating.

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

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

Allegation of non-compliance: Is an allegation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers (Louisiana Revised Statues 40:2009.14)

Appeal Rights: A due process system of procedures ensuring a participant or provider agency will be notified and have an opportunity to contest certain decisions.

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

Behavior Management Plan: A plan that addresses a specific behavior or set of behaviors of a participant. It is written by a licensed psychologist and updated annually at a minimum.

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

BPS: Bureau of Protective Services.

Centers for Medicare and Medicaid Services (CMS): The Federal agency in DHHS responsible for administering the Medicaid Program and overseeing and monitoring the State's Medicaid Program.

Community Situational Assessment: A paid or unpaid assessment that is done in a competitive employment setting in order to evaluate a participant's interest, skills and ability to do tasks related to a specific job or field of interest.

Competitive Employment: Employment in a community business where a majority of the persons employed are without a disability and/or the public has access and makes continuous use of the services of the business, and compensation is paid in accordance with the United States Fair Labor Standards Act of 1985 as amended.

Comprehensive Plan of Care (CPOC): A written plan designed by the participant, his/her legal representatives or responsible party, service provider(s) and others chosen by the participant and facilitated by the support coordinator that lists all paid and unpaid supports and services. It also identifies broad goals and time lines identified by the participant as necessary to achieve his/her personal outcomes.

Confidentiality: The process of protecting a participant or employee's personal information as required by HIPAA.

Decertification: Removal of a participant from the waiver by OCDD/WSS due to the inability of waiver services to ensure a participant's health and safety or due to non-compliance with waiver requirements by the participant. Decertification of a waiver participant is subject to review by the State Office Review Panel prior to notification of appeal rights and subsequent termination of waiver services.

Department of Health and Hospitals (DHH): The state agency responsible for administering Medicaid programs and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services.

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

Department of Social Services (DSS): The state agency responsible for administering social services including Louisiana Rehabilitation Services, Temporary Assistance for Needy Families (TANF), and Food Stamps.

Determination Process for System Entry: A process conducted by an appropriate professional in the Office for Citizens with Developmental Disabilities to determine if the level of disability of an individual meets criteria for a developmental disability.

Direct Support Worker (DSW): A person who is paid to provide hands-on services and active supports to a participant.

Discharge: Removal from the waiver for reasons established by OCDD/WSS.

Eligibility: The determination of whether or not a participant qualifies to receive waiver or targeted case management services based on established criteria set by DHH.

Employment Networks (ENs): Under the Ticket to Work, any agency or instrumentality of a state (or political subdivision), or a private entity that takes responsibility for the actual delivery of services or the coordination/referral of services. Employment Networks can be a single entity, a partnership or alliance of entities (public and/or private), or a consortium of organizations

collaborating to combine resources to serve Ticket-holders. Louisiana Rehabilitation Services is an EN.

Enrollment: The process of executing an agreement or contract with a potential provider for participation in the Medicaid program if the agency meets the necessary requirements.

Exploitation: The illegal or improper use or management of an adult with disability funds, assets or property, or the use of an adult with disability's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 14:403.2)

Facility-Based Assessment: A paid or unpaid assessment that is done in a provider-owned or leased setting where the majority of people in attendance have a disability in order to determine a participant's interest, skills and ability to do tasks related to a specific job or field of interest.

Financial Resources: Income, savings, property, insurance plans, government benefits, railroad/veteran's benefits, trust funds or other resources that are directly owned or connected to an individual participant that may count toward resource limits under Medicaid eligibility rules.

Fiscal Intermediary (FI): The entity that DHH contracts with to pay the Medicaid claims. Refer to MMIS. Unisys Corp. is the current FI.

Fixed Annual Allocation: A yearly amount provided for waiver service that is contingent upon available resources and an annual review of the participant's eligibility for services.

Freedom of Choice (FOC): The process that allows a participant to review all support coordination and service provider agencies in order to freely select agencies of his/her choice.

Goals: Broad and often abstract statements of a participant's needs and desires, usually with long-range time lines.

HIPAA: Health Insurance Portability and Accountability Act.

Home and Community-Based Services (HCBS): An optional Medicaid program established under Section 1915 (c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care. It provides a collection of supports and services available through an approved CMS waiver that are provided in a community setting by OCDD/WSS through enrolled providers of specific Medicaid services and targeted case management agencies. These supports and services enable participants who would otherwise qualify for institutional care to remain in a community-based setting.

Host Company: The community business (es) where a participant(s) perform work in exchange for wages; such remuneration is paid to a provider-owned company who in turn pays the participant(s).

ICF/DD: Intermediate Care Facility/Developmentally Disabled. Formerly known as ICF/MR.

Individualized Service Plan (ISP): A written agreement created by a service provider that specifies the long-range goals, short-term objectives, specific strategies, or action steps, assignment of responsibility, and time frames for completion or review. It is signed by the participant, his/her legal representative(s) and other support team members

Informal Incidental Learning Opportunities: Spontaneous actions or transactions which occur as a by-product of an identified goal on an ISP and which increase particular knowledge, skills, or understanding. Informal incidental learning opportunities includes such things as learning from mistakes, learning by doing, learning through networking, and learning from interactions with others.

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

Initial Job Support and Retention: Formerly known as "follow-along" services, those supports provided on a short or long term, intermittent or ongoing basis that assist a participant in retaining competitive employment.

Institutionalization: Placement of a participant in any inpatient facility including a hospital, intermediate care facility for the developmentally disabled, nursing facility, or psychiatric hospital.

Intake: The screening process conducted by the Office for Citizens with Developmental Disabilities consisting of activities necessary to determine the need and eligibility for waiver or state general funded services, including support coordination.

Job Accommodation: Physical adjustments or changes that are made to a workplace that helps an employee successfully perform the basic duties of a position.

Job Analysis: The process of identifying and determining the tasks and requirements that is necessary for a given job. Job analysis includes the essential functions or the job duties which are critical to the performance of the job including but not limited to the frequency and duration of each task, the environment in which the tasks are performed, the job qualifications or skills an individual must possess to perform the essential functions, and the equipment used to complete the task.

Job Restructuring: Formerly known as job carving, an adjustment or change that is made to a job that helps an employee successfully perform the position's basic duties but does not change essential job functions.

Licensure: A determination by HSS that a service provider agency meets the state requirements to provide specific services to a population.

Linkage: Act of connecting a participant to a specific support coordination or service provider agency.

Lifetime Entitlement: A service or resource that is provided without regard to redetermination of eligibility or resource requirements.

LOC: Level of Care

Long-Term Support: Paid staff or unpaid members of a participant's support network who provide assistance when needed or as scheduled over extended periods of time in order for the participant to remain living and/or working in the community.

Louisiana Rehabilitation Services (LRS): The agency in Louisiana under the Department of Social Services charged with providing vocational rehabilitation services to qualified persons. For more information go to http://www.dss.state.la.us

LTC: Long Term Care.

MD: Medical Doctor

Medicaid/Medicaid Program: Medical assistance provided under the State Plan approved by the Centers for Medicare and Medicaid Services (CMS) under Title XIX of the Social Security Act and under approved waivers of the provisions of that law.

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

Medicaid Eligibility Determination (Form 90-L): Form signed by licensed physician and used by Medicaid to establish a Level of Care (LOC). In the Supports Waiver a participant must meet an Intermediate Care Facility/Developmentally Disabled (ICF/DD) LOC in order to be offered a waiver opportunity.

Medicaid Fraud: According Louisiana Revised Statute 14:70. 1, Medicaid fraud is an act of any person, who, with the intent to defraud the state through any medical assistance program

created under the federal Social Security Act and administered by the DHH. This includes: (1)Presenting for allowance or payment any false or fraudulent claim for furnishing services or merchandise; (2) Knowingly submitting false information for the purpose of obtaining greater compensation than which he is legally entitled for furnishing service or merchandise; or (3)Knowingly submitting false information for the purpose of obtaining authorization for furnishing service or merchandise. Whoever commits the crime of Medicaid fraud shall be imprisoned, with or without hard labor, for nor more than five years, or may be fined not than $20,000, or both.

Microenterprise: A business typically employing 6 or fewer individuals, with start-up financing needs of $35,000 or less and does not have access to conventional sources of capital.

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

Monitoring: The ongoing oversight of the provision of waiver and other services in order to determine that they are furnished according to the participant's plan of care and effectively meet his/her needs, including health and welfare.

Native Language: The language normally used by the participant and his/her support network, and may include American or English sign language and other non-verbal forms of communication.

Natural Supports: Persons who are not paid to assist a participant in achieving his/her personal outcomes.

Objectives: Narrow, precise, tangible and concrete statements that identify the way a goal will be achieved within specified short-range time lines.

Office for Citizens with Developmental Disabilities Waiver Support and Services (OCDD/WSS): The operating authority for the Supports Waiver as designated by BHSF. The OCDD/WSS is responsible for directing the coordination and approval of all services and supports necessary for the planning development, and evaluation of all supports and services to people with developmental disabilities ages 18 and older who are participants in the Supports Waiver.

On the Job Training (OJT): On-The-Job Training (OJT) is a benefit funded through the federal Workforce Investment Act (WIA) and accessed through One Stop Shops. OJT provides an opportunity for employers to receive financial assistance for training new employees in the skills needed to perform effectively.

One Stop Centers: Centers established under the federal Workforce Investment Act in 1998 in each state. Often called Workforce Development, One Stop Shops or One Stop Career Centers, they are designed to assist people to enter the workforce, gain employment, and advance their careers. One Stop Centers have the responsibility to meet the range of needs of jobseekers in their communities, that is to say One Stop Centers are required to serve all jobseekers, including jobseekers with disabilities. Inherent in that charge is providing universal access to the center and the services it offers to the citizens of the community it serves.

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

Participant: An individual who has participated in the OCDD Determination Process for System Entry and met the criteria for a developmental disability and the Medicaid Eligibility Determination and application for Home and Community-Based Services process and been determined eligible for Medicaid and has been offered an opportunity to participate in the Supports Waiver.

Participant's Legal Representative/Responsible Party: An individual acting on behalf of a participant. If the participant is interdicted, the legal representative must be a curator appointed by a court of competent jurisdiction. If the participant is a competent major, the responsible party can be an individual or group who is designated by the participant to act as an official agent in dealing with DHH and/or a provider.

Participant's Needs: Non-funded and funded services that are essential to a participant's health, safety and welfare while living in the community

Participant Profile: An overview of a participant's needs and available resources, skills and preferences that is essential to him/her to achieving specific goals and objectives.

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

Person-Centered Planning: A process directed by the participant or the participant's responsible party or legal representative that is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant.

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

Physical Environment: The participant's place of residence, work or day program.

Placement Plan: Plan created by the service provider containing information used to identify specific vocational needs a participant has in areas of interests, work days, hours, transportation,

funding supports, social security issues, social environment needed, physical conditions and accessibility issues, pay scale desired, strengths and weaknesses.

Prior and Post Authorization (PA): The authorization for service delivery based on the OCDD/WSS approved CPOC. Prior authorization that must be obtained before any services can be provided and post authorization must be approved before services delivered will be paid.

Pre-Certification Visit: The visit the OCDD/WSS Regional Office makes to a physical location identified by the participant and his/her responsible party or legal representative(s) and/or family members where, at a minimum the participant and his/her representative(s) are in attendance in order to ensure that waiver planning and services, rights, responsibilities, methods of filing grievances and/or complaints, abuse/neglect and possible means of relief have been fully explained and that all parties are in agreement to move forward with waiver services.

Provider: Any individual or entity furnishing Medicaid services under a provider and/or licensing or certification agreement with DHH and other applicable state agencies.

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

Provider Enrollment: Another term for enrollment.

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

QI: Quality Improvement.

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

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

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

Request for Services Registry (RFSR): The process by which an individual verifies his/her desire to participate in the Supports Waiver.

SCORE: A group that provides resources and expertise to maximize the success of existing and emerging small businesses. For more information: www.SCORE.org.

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

Self Employment: Self-employment is the process of actively earning income directly from one's own business, trade, or profession. Persons are considered self-employed if they are responsible for obtaining or providing a service or product; earn income directly from their own business; are not required to have federal income tax and FICA payments withheld from their earnings; are not required to complete an IRS W4 form for an employer; and are not covered by worker's compensation.

Self-Neglect: The failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 14:403.2)

Service Provider: An agency holding proper licensure or certification, enrolled with HSS as a provider of specific Supports Waiver service(s) and listed on the FOC who furnishes medical, social, educational and other support services identified by the participant on his/her CPOC.

Standardized Assessment: A tool used to collect, analyze and interpret information about an individual for the purpose of making decisions concerning the services and supports to address a participant's needs.

State Data Contractor: Entity under contract to DHH which manages the Request for Service Registry, extends waiver and support coordination freedom of choice offers to individuals and coordinates prior and post authorization of services.

Sexual Abuse: Any sexual activity between a participant and staff without regard to consent or injury. Any non-consensual sexual activity between a participant and another person; or any sexual activity between a participant and another participant or any other person when the participant 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 participant to perform sex with any other person when participant is not competent to refuse.

Social Environment: The network of friends, families, advocates, paid staff, and other members of the community with whom the participant chooses to interact.

SOE: Statement of Eligibility or Summary of Evidence issued by the SPOE.

SPOE: Single Point of Entry. OCDD Regional Offices, Human Services Authorities and Human Services Districts are the SPOEs for all developmental disability services, including Home and Community-Based Waivers.

SSA: Social Security Administration.

SSN: Social Security Number.

State-General Funded Vocational and Habilitative Services: Services that provided supported employment, day habilitation and prevocational services through yearly allocation by the Louisiana Legislature without federal matching funds.

Support Coordination: Formerly known as case management and also known as Targeted Case Management. This service is provided through the Medicaid State Plan and is not a waiver service. Support coordination is a method designed to accommodate the array of supports and services needed by a participant through a coordinated effort in a cost effective, person-centered manner. Support coordination is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the misutilization of facilities and resources. Support coordination matches the appropriate intensity of services with the participant's needs over time.

Support Coordinator: Formerly known as a case manager. A person who is employed by a public or private entity compensated by the State of Louisiana through Medicaid State Plan Targeted Case Management services to create and coordinate a comprehensive plan of care that identifies all services and supports deemed necessary for the participant to remain in the community as an alternative to institutionalization.

Support Team: A team comprised of the participant, the participant's legal representative(s), family members, friends, support coordinator, direct service providers, medical and social work professionals as necessary, and other advocates, who assist the participant in determining needed supports and services to meet the participant's identified personal outcomes. Medical and social work professionals may participate by report. All other support team members must be active participants.

SUR: Surveillance Utilization Review. This program is operated by the FI in partnership with the Program Integrity Section. It reviews providers compliance with Louisiana Medicaid polices and regulations, including investigating allegations of excessive billing.

Targeted Case Management: See Support Coordination and Support Coordinator.

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

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

Work Activity Training: Paid or unpaid training on a task that is done in a provider-owned or leased facility-based setting that may or may not be related directly to a specific job or position, but may be transferable to a number of jobs/positions.

Work Hardening Skills: Skills associated with any job, such as showing up on time, taking appropriate breaks, and completing an entire shift.

Work Incentives, Planning and Assistance Project (WIPA): Known as BPAO until September of 2006, WIPA is a federal program provided in Louisiana to provide all Social Security Administration beneficiaries with disabilities, including transition-to-work aged youth, access to benefits planning and assistance services. WIPA projects provide services that are different from those services provided by Employment Networks.

Work Opportunities Tax Credit (WOTC): The Work Opportunity Tax Credit (WOTC), authorized by the Small Business Job Protection Act of 1996 (P. L. 104-188), is a federal tax credit that encourages employers to hire targeted groups of job seekers by reducing employers' federal income tax liability.

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

HIPAA CODE NAME	SERVICE DESCRIPTION	HIPAA CODE	MODIFIER	RATE	STANDARD UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Supported Employment	Individual Job, Self-Employment or Microenterprise Job Assessment, Discovery and Development	H2024	UK	$92.00	1 day	6 or more hours	120
Supported Employment	Group Employment Job Assessment, Discovery and Development	H2024	No modifier	$75.00	1 day	6 or more hours	20
Supported Employment	Individual Job, Self-Employment or Microenterprise Initial Job Support and Retention	H2026	TS	$50.00	1 day	1 or more hours	240+
Supported Employment	Group Employment Initial Job Support and Retention One staff to one-two participant ratio	H2026	TT	$75.00	1 day	1 or more hours	240+
Supported Employment	Group Employment Initial Job Support and Retention One staff to three-four participant ratio	H2026	UQ	$62.00	1 day	1 or more hours	240+
Supported Employment	Group Employment Initial Job Support and Retention One staff to five-eight participant ratio	H2026	No modifier	$46.50	1 day	1 or more hours	240+
Day Habilitation	Day Habilitation One staff to one participant ratio	T2020	TT	$72.50	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240-254
Day Habilitation	Day Habilitation One staff to two-four participant ratio	T2020	UQ	$60.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240-254
Day Habilitation	Day Habilitation One staff to five to eight participant ratio	T2020	No modifier	$45.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240-254

HIPAA CODE NAME	SERVICE DESCRIPTION	HIPAA CODE	MODIFIER	RATE	STANDARD UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Prevocational Habilitation	Prevocational services one staff to one participant ratio	T2014	TT	$72.50	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240
Prevocational Habilitation	Prevocational services one staff to two to four participant ratio	T2014	UQ	$50.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240
Prevocational Habilitation	Prevocational services one staff to five to eight participant ratio	T2014	No modifier	$35.00	1 day (must be scheduled a minimum of 1 day each week)	5 or more hours	240
Respite Attendant Care Services	Center based respite In-home respite	T1005 S5125	HQ No modifier	$3.50	15 minutes	N/A	428
Habilitation Supported Employment	Habilitation	T2019	No modifier	$3.50	15 minutes	N/A	285
Personal Emergency Response System	PERS Installation	Z0058	No modifier	$30.00	One time	N/A	1 in current residence and 1 each time participant moves to new residence
Personal Emergency Response System	PERS monthly maintenance	Z0059	No modifier	$28.00	Monthly	N/A	12

APPENDIX B

JOB ASSESSMENT, JOB DISCOVERY, AND JOB DEVELOPMENT COMPLETION FORM

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES
SUPPORTS WAIVER (SW)

Job Assessment, Job Discovery, and Job Development Completion Form

Instructions: This form is to be used for all requests for Job Assessment, Job Discovery, and Job Development. The support coordinator will complete Section 1 and must submit with the ISP to the OCDD Regional Office. Section 2 will be completed by the OCDD Regional Office. When completed, OCDD Regional Office will send it to the support coordinator who will forward it to the provider. Section 3 will be completed by the enrolled service provider. If any adjustments are to be made to the services/timelines, the individual's support team members must submit the revised the ISP (i.e., objectives, time-lines), the revised ISP along with the support team signature sheet. Section 4 will be completed by the support coordinator and signed by the recipient/guardian. All documentation is to be forwarded to the OCDD Regional Office.
All signatures are mandatory.

SECTION 1: MUST BE COMPLETED BY THE SUPPORT COORDINATOR

RECIPIENT'S NAME: _____ MEDICAID ID #: _____

ADDRESS: _____ DIAGNOSIS: _____

SUPPORT COORDINATION AGENCY: _____ PHONE #: ( )

ADDRESS: _____ PROVIDER #: _____

PROVIDER OF SUPPORTED EMPLOYMENT ACTIVITIES: _____ PHONE #: ( )

ADDRESS: _____ PROVIDER #: _____

DESCRIPTION OF REQUESTED ACTIVITIES: (JOB ASSESSMENT, JOB DISCOVERY, AND/OR JOB DEVELOPMENT) _____ DATE SERVICE REQUESTED: _____

ANTICIPATED COMPLETION DATE: _____

REQUESTED UNITS: _____ ISP AND TIMELINE ATTACHED: YES/NO PROCEDURE CODE: _____

PROVIDER AGREEMENT SIGNATURE: _____ DATE: _____

SUPPORT COORDINATION AGENCY AGREEMENT SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY AGREEMENT SIGNATURE:: DATE:

SECTION 2 – OCDD AGREEMENT DETAILS: MUST BE COMPLETED BY THE OCDD REGIONAL OFFICE

APPROVED ACTIVITY: (JOB ASSESSMENT, JOB DISCOVERY, AND/OR JOB DEVELOPMENT) _____

PROCEDURE CODE: _____ APPROVED UNITS: _____

OCDD SIGNATURE: _____ DATE OF APPROVAL: _____

APPROVAL AND SUBSEQUENT PRIOR AUTHORIZATION BY THE OCDD OFFICE DOES NOT OVERRIDE ANY LIMITS THE INDIVIDUAL HAS ALREADY MET.

SECTION 3 – PROVIDER VERIFICATION OF COMPLETION: MUST BE COMPLETED BY ENROLLED SERVICE PROVIDER

DESCRIPTION OF ACTIVITY: (JOB ASSESSMENT, JOB DISCOVERY, AND/OR JOB DEVELOPMENT) _____ NUMBER OF UNITS PROVIDED: _____

DATE ACTIVITY BEGAN: _____ DATE ACTIVITY COMPLETED: _____

PROVIDER'S SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY SIGNATURE: DATE:

SECTION 4 – SUPPORT COORDINATOR'S POST AUTHORIZATION SUMMARY: MUST BE COMPLETED BY THE SUPPORT COORDINATOR

DATE COMPLETED ACTIVITY VERIFIED: _____ APPROVED UNITS: _____

COMMENTS: _____

SUPPORT COORDINATOR'S SIGNATURE: _____ DATE: _____

RECIPIENT/FAMILY ACCEPTANCE SIGNATURE: DATE:

SUPPORT COORDINATION AGENCY SUBMITS TO OCDD OFFICE FOR MODIFIED PA RELEASE

Job Assessment, Job Discovery, Job Development Form
Instructions
SUPPORTS WAIVER (SW)

SECTION 1

a. The support coordinator will complete information in Section 1 once the participant/participant's representative has chosen a direct service provider and an approved ISP is received.

b. The direct service provider will submit the portion of the ISP covering Job Assessment, Job Discovery and Job Development services to the support coordinator with measurable goals, objectives, and time-lines in order to receive prior-authorization. The direct service provider will ensure that the ISP is signed and dated by the participant/participant representatives and support team members indicating agreement with the goals, objectives and time lines.

c. The support coordinator will ensure that the service provider is aware of the activities involved in Job Assessment, Job Discovery, and Job Development. The service provider will bear the burden of liability with all applicable licensing requirements in effect for the area of the state in which the activity is being conducted.

Description of Requested Activity	Support coordinator will enter the Procedure Name: (Job Assessment, Job Discovery, and/or Job Development)
Date Service Requested	Support coordinator will enter the date that the service (Job Assessment, Job Discovery, and/or Job Development) was requested.
Anticipated Completion Date	Support coordinator will enter the anticipated completion date of the activity (Job Assessment, Job Discovery, Job Development) as indicated by service provider.
Requested Units	Support coordinator will enter the number of units requested for the activity. (Activities will be authorized for a maximum of 120 units in a service year for individual Job Assessment, Job Discovery and Job Development, and 20 units in a service year for group Job Assessment, Job Discovery and Job Development: A standard unit of service is 6 or more hours per day.)
ISP and Timeline Attached	Notes whether or not the ISP and time line are attached
Provider Agreement Signature	Presence of a signature of service provider indicates agreement to provide the activity and anticipated completion date.
Support Coordination Agency Agreement Signature	Presence of a signature of support coordination agency representative indicates agreement with the need of the activity, number of units, and anticipated completion date.
Recipient/Family Agreement Signature	Presence of a signature indicates approval of the recipient/family, and agreement with the number of units and anticipated completion date.

The support coordinator will forward the Job Assessment, Job Discovery, and Job Development Form along with the ISP to the OCDD Regional Office for review and completion of Section 2.

SECTION 2

a. The OCDD Regional Office will enter the approved activity, the procedure code of the approved activity and the number of units of the approved activity (only the amount approved shall be reimbursed).

b. A regional office staff signature in the section labeled "OCDD Agreement" indicates authorization of the requested activity and unit amount payable to the provider for the activity.

c. The OCDD Regional Office staff will enter the date of the approval for the activity.

d. The approval and subsequent prior authorization by the regional office does not override any limits the individual has already met.

Approved Activity	OCDD will list the type of activity approved (Job Assessment, Job Discovery and/or Job Development).
Approved Units	Number of standard service units approved (only the amount approved shall be reimbursed)
Procedure Code	Support coordinator will indicate appropriate procedure code for the activity.
OCDD Agreement Signature	Indicates authorization of the requested activity and unit amount payable to the provider for the activity. (However, the approval of the OCDD Office does not override any limits the individual has already met.)
Date Activity Approved	Actual date OCDD approved activities

The OCDD Regional Office will send the form and ISP (and any attachments) back to the support coordinator who will forward it to the provider.

a. The selected service provider will complete this section of the form after the activity is completed.

The service provider will then forward the form, ISP, and any additional documentation to the support coordinator.

Job Assessment

To receive post-authorization for Job Assessment, one or more of the following documents must be submitted along with this form to the support coordinator:

- Completed vocational assessment
- Completed job analysis
- Notes from community-based/facility-based situational assessments
- Participant profile
- Placement plan

Approval of Job Assessment documents will be based on the following:

- The objectives and time lines outlined in the ISP were met timely.
- Identification in the document(s) of basic guidelines a job would need to meet.
  These guidelines must include but are not limited to:
  - Specific career interest(s) are identified.
  - Maximum hours per week participant will consider working.
  - Minimum rate of pay participant will accept.
  - Benefits participant receives that might impact earnings, in particular SSI and/or SSDI.
  - Times of day participant will consider working.
  - Areas of town, city or parish(s) participant will consider working.
  - Transportation currently available to participant.
  - Current work strengths/skills that will help participant obtain job of his/her choosing.
  - Current barriers to participant obtaining job of his/her choosing.
  - If group employment is the career outcome, the staff ratio needed to support the participant.

Job Assessment activities for individual/self-employment/microenterprise will be authorized for a maximum of 120 standard units in a service year (a standard unit of service is 6 or more hours per day). Job Assessment activities for group employment will be authorized for a maximum of 20 standard units in a service year. Utilization of Job Assessment units will be counted towards the total available units for Job Assessment, Discovery and Development for a service year. Therefore, if 120 (individual job/self-employment/microenterprise) or 20 (group employment) standard units are utilized in a service year, Job Discovery and Development could not begin until the next service year. If all available units in Job Assessment, Discovery and Development are used for Job Assessment for a participant in one service year, only Job Discovery and Development activities and not Job Assessment will be authorized for the next service year.

Job Discovery and Development

Job Discovery and Development consists of one or more of the following activities:

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

- The following activities are included for self-employment/microenterprise:

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

  The participant may or may not be present during Job Discovery and Development activities. If the participant is not present, a signed and dated confidentiality form must be in the participant's record in his/her native language indicating that the participant has approved contacts, meetings, education or training to occur in his/her absence.

Documentation Requirements for Job Discovery and Job Development

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

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

Rates for Job Discovery and Development are paid per participant, not per group. Job Discovery and Development may be provided on one staff to multiple participant ratios. Documentation of Job Discovery and Development must be specific to each participant regardless of staff to participant ratio.

(When individual Job Discovery and Development is billed on one staff to multiple participant ratio, post authorization documentation must show individual outcomes. For example, if an employment specialist bills for two participants on the same day for the same time period, post authorization documentation must show that job development efforts were made for each individual according to his/her identified specific career interests. If both participants identified career interests are restaurant work, then billing could reflect a visit to one restaurant on behalf of both participants. However, if one participant's identified career interest is restaurant work and the other participant wishes to work in a medical setting, documentation must show visits to the specific type of business for each participant.)

NOTE: All activities are to be performed in the year the current ISP is approved, or an ISP amendment must be completed. Specific documentation that reflects the goals, objectives and time lines on the ISP related to those activities have been met must be submitted to the participant's support coordinator for post-authorization.

If an objective or time line cannot be met timely, the provider must facilitate changes prior to the end date of the objectives and time lines on the ISP and obtain support team members' dated signatures indicating agreement with the changes. Partial completion of Job Assessment, Discovery and/or Development of ISP objectives and time lines will not qualify for post authorization of payment.

Description of Activity	Description of activity provided and completed (attach appropriate documentation)
Units Provided	Number of standard service units provided (only the amount approved shall be reimbursed)
Provider's Signature	Presence of a signature indicates the activity has been completed by service provider as agreed upon.
Date Activity Began	Actual date the activities began
Date Activity Completed	Actual date of completion
Recipient/Family Signature	Presence of a signature verifies that the activity was completed.

ıe service provider will then provide the form with the original signature(s), ISP (amended ISP if changed), and documentation to the support coordinator who will then review the activity with the family and complete Section 4. This form, ISP, and documentation can be faxed to the support coordinator and the original form mailed to expedite the process.

SECTION 4

a. The support coordinator will complete this section and obtain the signature of recipient/family member indicating approval/agreement, and send a copy of the form, the ISP and necessary documentation to the OCDD Regional Office via fax or mail within ten (10) working days of the date of the actual completion of the activity.

b. The OCDD Regional Office staff, upon receipt of required documentation, will forward the information to the state data contractor.

Date Completed Activity was Verified	Date form (and attachments) were verified as having been completed by OCDD
Approved Units	Indicates number of approved units (only the amount approved shall be reimbursed)
Comments	Documentation noting any additional comments and/or information
Support Coordinator's Signature	Presence of a signature verifies acceptance of documentation that the activity was completed.
Recipient/Family Signature	Presence of a signature verifies that the activity was completed.

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

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

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

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

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

Preventive Instruction• those EMS measures that provide health information and explanation to the public to reduce the incidence of death and injury.

Scope of Practice• the range of duties and skills EMS professionals are expected to perform.

Specialized Knowledge and Skills• required for the practice of EMS means the current theory and practice taught in basic EMS education programs preparing persons for EMS professional certification as well as information in the biological, physical and behavioral sciences.

Specialty Care Transport Paramedic• those individuals who have met the requirements as approved by the EMS Certification Commission.

Student EMS Professional• a person who is engaged in learning experiences in a program of study leading to candidacy for certification to practice as a certified EMS professional. The term applies only when the person is participating in an integral part of the program of study.

Teaching of EMS• instructing EMS professional students and providing continuing EMS education to certified EMS professionals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2017.10.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Medical Services Certification Commission, LR 29:1828 (September 2003).

Chapter 7. Administrative Provisions

Subchapter A. Fees and Costs

Reserved.

Gene Salassi
Chairman

0309#034

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Community Supports and Services

Home and Community Based Services Waiver Program
Standards of Participation
(LAC 50:XXI.Chapter 1)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services promulgates the following Rule under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH• MEDICAL ASSISTANCE
Part XXI. Home and Community Services Waivers
Subpart 1. General Provisions
Chapter 1. Standards for Participation

§101. Provider Requirements

A. In order to be reimbursed by the Louisiana Medicaid Program, a service provider agency must comply with all of the requirements of this Part XXI.

B. General Provisions

1. For the purposes of this Part XXI, providers enrolled with the Department of Health and Hospitals (DHH) as a Home and Community-Based Waiver (HCBW) service provider on the effective date of this rule shall have two years to comply with these standards, including attending the Bureau of Community Supports and Services (BCSS) provider orientation for HCBW prior to requesting a provider enrollment visit by the Bureau of Community Supports and Services (BCSS).

2. If a provider is not accessible in their DHH geographical region, individuals and/or families may seek a provider outside of the DHH region with prior approval of BCSS. This approval must be documented in the individual's approved comprehensive plan of care (CPOC) and Freedom of Choice Form (FOC).

3. Providers are responsible for submitting written notification by certified mail to BCSS and Medicaid of any changes in address and/or telephone numbers within 10 days of the change.

4. In addition to agency internal employer reporting requirements, any employee or consultant/contractor of the enrolled provider who witnesses, learns of, is informed of, or otherwise has reason to suspect that an incident of abuse, neglect, or exploitation has occurred must report such incident in accordance with BCSS critical incident reporting, child and/or adult protection laws, and fully cooperate with the investigation of the incident.

C. Physical Facilities and Equipment

1. The provider shall maintain an office site in each region of operation.

a. Each site must house the case records and billing information for all individuals served by that office.

b. Each regional site must maintain a toll-free telephone line with 24-hour accessibility and manned by an answering service. The toll-free number must be given to individuals at intake or at the first meeting.

c. The provider must have daytime office hours that conform to the usual and customary operating hours of the local business community.

d. The provider must maintain a current brochure that outlines provider services, address and telephone numbers for distribution to the public.

2. The provider must obtain and maintain computer equipment, internet accessibility, and software as specified below:

a. IBM-compatible PC with a Pentium Processor 4 or later version, and/or capable of using specific software required by BCSS:

b. 1.44 MB 3.5 inch disk drive;

c. 32 MB of RAM or more;

d. 25 MB free hard drive space or more;

e. color monitor;

f. printer;

g. modem (28.2k or faster);

h. CD-ROM;

i. Windows 95 operating system or later version;

j. internet account with e-mail and web-browser software.

D. Provider Training

1. New providers shall attend the BCSS provider orientation for HCBW providers and meet all required standards prior to being enrolled as a waiver service provider. BCSS provider orientation will be held in January and June.

2. All enrolled providers will be required to attend an annual BCSS training conducted to continue enrollment. Additional training may be required by BCSS if deemed necessary.

3. Those employees having direct contact with recipients must obtain no less than 16 hours of basic orientation in addition to any individualized, specialized training needed to work with a recipient on a daily basis prior to becoming solely responsible for implementing that recipient's support plan.

4. All provider training shall be competency-based (results driven).

5. Training shall include, but is not limited to, the following:

a. abuse/neglect/incident reporting;

b. staff ethic, including the strict prohibition against soliciting consumers from other provider agencies, respectful interactions with people being supported, and the use of People First Language;

c. confidentiality, privacy rights, and HIPAA;

d. human and civil rights;

e. person centered planning;

f. personal outcomes;

g. consumer direction/self determination philosophy;

h. infection control/universal precautions, first aid and emergency procedures;

i. environmental emergency procedures;

j. provider policies and procedures;

k. documentation of services, progress notes, service logs, etc.

6. The provider shall have an employee designated as a training coordinator whose responsibilities include, but are not limited to, the following duties:

a. staff training;

b. staff development; and

c. maintenance of training records.

E. Personnel and Human Resources

1. Program or Executive Director

a. The program director or executive director shall meet the following requirements:

i. be a registered nurse (RN) and have one year of verifiable experience in direct service work with persons with disabilities;

ii. have a bachelor's degree in a human services field (such as, but not limited to, hospital or nursing home administration, physical therapy, occupational therapy, speech therapy, social work or psychology) or is currently enrolled in an accredited college and pursuing a bachelor's degree in a human services field. The individual will have a period of three years to complete the course of study; and

iii. have a minimum of one year verifiable work experience, post degree or have one year of experience while working on the degree, in planning and providing direct support to:

(a). persons with mental retardation or other developmental disabilities; or

(b). disabled adults; or

(c). elderly persons with chronic disabling illness; or

b. in the absence of having an employee that meets the qualifications in §101.E.1, the provider must have a contract with a person so qualified to serve as program director to assure that services are delivered as described in the approved CPOC.

2. Direct Support Staff. Direct support personnel/staff shall possess validated direct care abilities, skills and knowledge to adequately provide the care and support required by a recipient receiving waiver support services.

a. Direct support staff shall be at least 18 years old and possess a high school diploma, GED, a trade school diploma in the area of human services, demonstrated competency, or have verifiable work experience in providing support to individuals with disabilities.

3. The provider shall develop and implement policies and procedures for the recruitment, hiring, and retaining of qualified, competent personnel including:

a. obtaining at least three references from previous employers and/or work supervisors;

b. strategies to recruit and employ staff representative of the cultural and ethnic groups supported;

c. conducting criminal background checks on all employees prior to allowing the employee to work directly with individuals receiving HCBW services;

d. strategies for retaining competent staff and staff development;

e. compliance with Fair Labor and Child Labor laws;

f. agency backup plans for staff coverage when direct care staff fail to report for duty as scheduled. The plan must include strategies to assure that backup direct support staff have been trained in the individualized, specialized care and support needed;

g. protocol outlining how the agency will have staff available during emergencies or unexpected changes in the recipient's schedule;

h. a staff evaluation process that addresses the quality of the staff's support to individuals served and includes consumer satisfaction information from the recipient/guardian or authorized representative;

i. policies outlining the chain of command and supervisory roles including:

i. protocol for staff supervision;

ii. protocol for investigation and resolution of complaints regarding the staff's performance.

4. The provider must have an approved Quality Assurance/Quality Improvement (QA/QI) plan. The QA/QI plan shall include the following:

a. a process for obtaining input from recipient/guardian/authorized representative and family members of those receiving waiver supports;

b. a process for identifying the risk factors that put the recipients at high risk and affect or may affect or may affect health, safety, and/or welfare of individuals being supported;

c. accepted methods for data collection, frequency of collection, source of data, identification of thresholds, analysis of data and identification of trends and patterns in service delivery:

i. the provider shall develop strategies to benchmark service improvement over time;

ii. the QA/QI program outcomes shall be reported to the program director for action as necessary for any identified systemic problems.

5. The QA/QI plan must be submitted to BCSS in accordance with the following time schedule.

a. The QA/QI plan is due 60 days after documented QA/QI training by BCSS and annually thereafter.

b. Self-evaluation of QA/QI plan is due six months after the approval by BCSS of the QA/QI plan.

c. A self evaluation of the QA/QI program is to be submitted annually thereafter to BCSS.

6. The provider shall develop and implement system accountability for billing in keeping with generally accepted accounting principles and provide annual cost reports as requested by BCSS for systems evaluation.

F. License Documentation

1. The provider must adhere to all licensure regulations. The provider shall maintain a current license for all applicable areas of service provision and shall provide BCSS with current documentation of licensing including all deficiencies, corrective action plans and follow-up licensing reviews.

2. Providers not adhering to licensing regulations and/or not attending scheduled re-enrollment will be denied new referrals by Freedom of Choice. If the provider does not comply with these requirements, steps will be taken to disenroll the agency as a Medicaid provider for HCBW.

3. Providers operating under a provisional license or under an extended license due to noncompliance with licensing regulations must demonstrate satisfactory progress toward correction of the deficient practices in order to maintain provider standing for continued enrollment as a waiver service provider. Providers possessing provisional licenses due to noncompliance shall be removed from the Freedom of Choice list until all deficiencies have been corrected and a full license has been obtained.

4. Staff transporting an individual receiving HCBW services shall have a valid (current) driver's license, current liability insurance, and the vehicle shall be in safe operating condition as determined by a current inspection sticker.

G Fiscal Accountability

1. The new provider (applicant) shall establish a business plan which includes cash flow projections and which has been-reviewed by a fiscal entity (e.g., a CPA) who attests to the adequacy of the plan for meeting the provider's monthly overhead and payroll requirements on an ongoing basis. A notarized letter from the fiscal entity will serve as evidence and shall be available for review upon request by BCSS.

2. Existing providers shall have an established relationship with a fiscal entity (i.e., a bank) to assure fiscal stability and documentation in the form of liquid assets or the ability to secure approval for a line of credit.

3. Requirements for average rates of pay and/or benefit packages for direct support staff will be responsive to the overall funding of the services to the program by the DHH.

H. Records and Documentation

1. The provider shall comply with the Health Insurance Portability and Accountability Act of 1996, (HIPAA) as defined by the Centers for Medicare and Medicaid Services.

2. A complete and separate record for each individual served shall be maintained, including:

a. planning meeting minutes;

b. CPOCs;

c. service logs;

d. billing records;

e. progress notes;

f. eligibility records; and

g. all other pertinent documents.

3. The provider shall provide all case records and billing documents to BCSS as required for monitoring activities and investigations upon request on site or within two hours if records are stored off site.

4. The provider will maintain the following documents and provide them to BCSS upon request:

a. copies of the current approved CPOC, the current service plan and all CPOC revisions in the individual's case record and in the individual's home. (Note: These documents must be current and available);

b. documentation of payroll and services delivered within a time period must agree. Documentation of services delivered within a pay period will be recorded in the individual's home record;

c. updated and implemented service plan to meet the service changes warranted by CPOC revisions within five calendar days of receiving a copy of the approved CPOC revision;

d. a copy of the behavior support plan, if one is required, in the recipient's home.

5. The provider shall maintain documentation to support that services were rendered as per the approved CPOC and service plan. The provider shall:

a. maintain documentation of the day-to-day activities of the recipient (service logs and progress notes);

b. maintain documentation detailing the recipient's progress towards his/her personal outcome;

c. maintain documentation of all interventions used to ensure the recipient's health, safety and welfare. (Note: interventions may include, but are not limited to, medical consultations, environmental and adaptive interventions, etc.)

6. The provider shall develop written policies and procedures relative to the protection of recipient's rights which include, but are not limited to:

a. human dignity/respectful communications;

b. person-centered planning/personal outcomes;

c. community/cultural access;

d. right to personally manage his/her financial affairs, unless legally determined otherwise or he/she gives informed consent;

e. right to refuse service/treatment;

f. civil rights (such as right to vote).

I. Discharges and Transfers

1. The provider's responsibilities for voluntary planned transfers or discharges from their agency shall include:

a. obtaining of a written request for transfer to another agency and the expected transfer date/time from the individual or his/her authorized representative;

b. notifying the recipient's case manager within 24 hours for planning to begin;

c. allowing the case manager no less than two weeks (14 calendar days) and up to 30 days (if needed) for planning the transfer, unless it is for an emergency placement;

d. participating in the planning meeting facilitated by the case manager who assures the availability of appropriate services through the receiving agency; and

e. with the written consent from the recipient, both the transferring and the receiving agencies shall share responsibilities for ensuring the exchange of medical and program information which shall include:

i. current CPOC;

ii. current service plan;

iii. a summary of behavioral, social, health and nutritional status; and

iv. any other pertinent information.

2. The provider must have written policies and procedures for the management of involuntary discharges/transfers from their agency.

a. Involuntary transfers/discharges from their services may occur for the following reasons:

i. medical protection of the well being of the individual or others;

ii. emergency situations (i.e., fire or weather related damage); or

iii. any direct threat to the recipient's health, safety and/or welfare.

b. Involuntary transfers/discharges may occur when a provider identifies an inability to provide the services indicated in the recipient's CPOC, but only after documented reasonable accommodations have been tried and have failed.

c. Provider responsibilities include submission of a written report to the BCSS regional office, detailing the circumstances leading up to the decision for an involuntary transfer/discharge and provision of the documentation of the provider's efforts to resolve issues encountered in the provision of services.

d. All team conferences shall reflect a person-centered process and be conducted with the recipient, guardian or authorized representative, case manager and the appropriate provider personnel to develop or update the CPOC.

e. The recipient, guardian or authorized representative will be notified in writing at least 15 calendar days prior to the transfer or discharge fom the provider agency. The individual's rights shall be assured throughout the process. The written notification shall include:

i. the proposed date of transfer/discharge;

ii. the reason for the action; and

iii. the names of personnel available to assist the individual throughout the process.

f. The service provider shall provide the recipient, guardian, or authorized representative with information on how to request an appeal of the decision for involuntary discharge.

i. The recipient may request reconsideration through the service provider's grievance policy and procedures.

ii. The recipient may request an informal reconsideration hearing with BCSS and the discharging service provider.

iii. If the recipient is not satisfied with the results of the informal reconsideration hearing, an appeal may be filed with the DHH Appeals Section by notifying the regional BCSS office or the DHH Bureau of Appeal.

J. Emergency Situations

1. Immediate jeopardy situations shall be handled immediately and the recipient's guardian or authorized representative, BCSS regional office, and the case manager must be notified immediately, no later than 48 hours after the provider's direct support staff and/or the provider's administrative staff learns of the immediate jeopardy situation.

a. The notification shall include:

i. the anticipated action;

ii. that the action will take place within 48 hours unless an emergency situation exists; and

iii. the names of personnel available to assist the individual and/or their family through the process.

b. A critical incident report and investigation must begin as soon as possible after the individual is safe.

2. Critical incidents shall be reported to all appropriate law enforcement agencies as directed by state law and as directed in the Bureau's critical incident policy and to BCSS within two hours of the agency's Executive Director or his/her designated representative's first knowledge of the incident. If after business hours, a message shall be left on the BCSS toll-free line voice mail and a critical incident report must be sent via FAX on the next business day.

a. Critical incident updates shall be sent to BCSS within 72 hours and a final report to BCSS up to the 30 days from the incident.

b. The waiver service provider's responsibilities for critical incident reporting are:

i. immediately assuring the recipient's health and safety;

ii. reporting the incident to BCSS and the case manager;

iii. conducting an internal investigation;

iv. cooperating with all critical incident investigations;

v. resolution of all critical incidents and complaints against the provider; and

vi. implementing a plan of correction for problems identified in the course of critical incident investigations.

K. Recipient Provisions and Rights

1. The center-based respite provider may serve recipients residing in other regions other than the region in which it is located. The selection should be approved by BCSS and included in the recipient's CPOC.

2. An individual is linked to a provider for a period of six months at a time.

a. The recipient may not transfer to a different provider until after the six-month period without "Good Cause."

b. The provider shall not refuse to serve any individual who chooses their agency, unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The BCSS must be notified of the circumstances.

c. Requirements in Paragraph 2.a-b above can only be waived by BCSS.

3. The BCSS toll-free help line number must be included in the contact packets left in the recipient's home.

4. The provider shall encourage and support the recipient in the development of the CPOC and provider service plan by:

a. obtaining the recipient's personal choices, vision, and preferences and incorporating them into the individual's person-centered CPOC;

b. assessing the recipient's:

i. skills;

ii. needed supports; and

iii. health, safety and welfare needs.

c. development of strategies to meet the recipient's service needs and timely development of the service plan to implement the strategies; and

d. the development of a process to monitor the ongoing implementation of the plan.

L. Case Management. The provider shall have a written working agreement with the case management agency serving the recipient. The agreement shall include:

1. written notification of the time frames for CPOC planning meetings;

2. the timely notification of the meeting dates and time to allow for provider participation;

3. how agencies will exchange information, such as notification of changes in the CPOC or in service delivery; and

4. assurance that the provider sends the appropriate provider representative to the planning meetings as invited by the recipient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:1829 (September 2003).

§103. Agency Responsibilities

A. Both federal and state laws and regulations authorize the Department of Health and Hospitals to maintain the programmatic and fiscal integrity of the Medicaid Home and Community-Based Services Waiver Program. The Bureau of Community Supports and Services is charged with the responsibility to set the standards, monitor the outcomes and apply administrative sanctions for failures by service providers to meet the minimum standards for participation. All failures to meet minimum standards shall result in a range of required corrective actions including, but not limited to, removal from the Freedom of Choice listing, a citation of deficient practice, a request for a corrective action plan and/or administrative sanctions. Continued failure to meet minimum standards shall result in loss of referral of new HCBW recipients and/or continued enrollment as a home and community-based waiver service provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:1833 (September 2003).

David W. Hood
Secretary

0309#101

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Medicaid Eligibility• TANF
Elimination of Work Related Sanctions

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing eliminates the consideration of Temporary Assistance to Needy Families work requirements in determining Medicaid eligibility.

Implementation of this Rule is subject to approval by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

David W. Hood
Secretary

0309#100

RULE

Department of Social Services
Office of Family Support

Child Care Assistance Program (CCAP)
Conditions of Eligibility; Activity Hours; Payment
(LAC 67:III.5103 and 5109)

The Department of Social Services, Office of Family Support, has amended the Louisiana Administrative Code, Title 67, Part III, Subpart 12, Child Care Assistance Program.

To ensure that funding is available to as many low-income families as possible, the agency has decreased the percentage of child care costs paid for by the agency and increased the number of required activity hours for parents receiving low-income child care. The agency has also amended §5109.B.1.c.ii to change "casehead" to "head of household" and §5109.D for technical reasons only.•

Title 67
SOCIAL SERVICES
Part III. Office of Family Support
Subpart 12. Child Care Assistance
Chapter 51. Child Care Assistance
Subchapter B. Child Care Assistance Program
§5103. Conditions of Eligibility

A. ...

B. Low-income families not receiving FITAP cash assistance, including former FITAP recipients who are given priority consideration, must meet the following eligibility criteria.

CLAIMS SUBMISSION AND PROCESSING

This section goes through the process of billing for Medicaid Services. When filing for reimbursement of services rendered providers can bill their claims electronically on the 837P format or hardcopy using the CMS 1500 claim form.

ELECTRONIC CLAIMS PROCESSING

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

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

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

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

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

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

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

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

Reminders Concerning Electronic Claims Filing

- Denied claims may be resubmitted electronically unless the denial code states otherwise. This includes claims that have produced a denied claim turnaround document (DTA).
- If errors exist on a file, the file may be rejected when submitted. Errors should be corrected and the file resubmitted for processing.
- The total amount of the submitted file must equal the amount indicated on the Unisys response file.
- To check on a file or report submission of a second file before a 24-hour period has lapsed, call (225) 237-3200, ext. 3244 or 3335. **Please have your EMC submitter ID ready and identify the type of claim you are calling about.**
- To request EMC specifications or EMC enrollment packets, call (225) 237-3303.

To discuss testing/test transmissions, questions concerning EMC specifications, or electronic remittance advices, call the EDI Help Desk at (225) 237-3318

HARD COPY CLAIMS PROCESSING

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

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

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

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

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

Attachment Size

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

Highlighting Specific Information

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

Changes to Claim Forms

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

Data Entry

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

General Reminders

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

Claims Documentation

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

1500

HEALTH INSURANCE CLAIM FORM Waiver

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #) X	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							695231546013		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
JAYCO, TRAVIS			07 31 1972		M F				
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
			Self Spouse Child Other						
CITY		STATE	8. PATIENT STATUS				CITY		STATE
			Single Married Other						
ZIP CODE	TELEPHONE (Include Area Code)		Employed Full-Time Student Part-Time Student				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)				a. INSURED'S DATE OF BIRTH MM DD YY		SEX
			YES NO						M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX	b. AUTO ACCIDENT?		PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME		
		M F	YES NO						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES NO						
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 PROVIDER OR OTHER SOURCE	17a. 17b. NPI	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. 351.0 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 417365219

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 01 07	07 01 07	12		S5125	U1	1	392 00	112		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 392 00	29. AMOUNT PAID $	30. BALANCE DUE $ 392 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Mary Lou 7/31/07	a NPI b	Waiver Provider #1 Carlton, LA
SIGNED DATE		a 9999999991 b 1418230

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Revised CMS-1500 Claim Form for Professional and General Services

Instructions

Instructions for completing the CMS-1500 (08-05) follow. Items to be completed are **required, situational, or optional. Required** information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned. These claims cannot be processed until corrected and resubmitted by the provider. **Situational** information may be required (but only in certain circumstances as detailed in the instructions below). **Optional** means that entry of information is at the discretion of the provider. Claims should be submitted to:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

Note: DME and Waiver providers must continue to write "DME" or "WAIVER" as appropriate in large letters at the top of the claim form

CMS-1500 Billing Instructions for Professional and General Services

Locator #	Description	Instructions
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.
3	Patient's Birth Date Sex	**Situational** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.
4	Insured's Name	**Situational** – Complete correctly if the recipient has other insurance; otherwise, leave blank.
5	Patient's Address	**Optional** – Print the recipient's permanent address.
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.
8	Patient Status	**Optional.**
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.
9a	Other Insured's Policy or Group Number	**Situational** – If recipient has no other coverage, leave blank. If there is other coverage, the state assigned 6-digit TPL carrier code is **required** in this block (the carrier code list can be found at www.lamedicaid.com under the **Forms/Files** link). Make sure the EOB or EOBs from other insurance(s) are attached to the claim.
9b	Other Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.
9c	Employer's Name or	**Situational** – Complete if appropriate or leave blank.

Locator #	Description	Instructions
	School Name	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.
11	Insured's Policy Group or FECA Number	**Situational** – Complete if appropriate or leave blank.
11a	Insured's Date of Birth Sex	**Situational** – Complete if appropriate or leave blank.
11b	Employer's Name or School Name	**Situational** – Complete if appropriate or leave blank.
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.
14	Date of Current Illness / Injury / Pregnancy	**Optional.**
15	If Patient Has Had Same or Similar Illness Give First Date	**Optional.**
16	Dates Patient Unable to Work in Current Occupation	**Optional.**
17	Name of Referring Provider or Other Source	**Situational** – Complete if applicable. In the following circumstances, entering the name of the appropriate physician block is **required**: If services are performed by a CRNA, enter the name of the directing physician. If services are performed by a nurse practitioner or clinical nurse specialist, enter the name of the directing physician.

Locator #	Description	Instructions
		If the recipient is a lock-in recipient and has been referred to the billing provider for services, enter the lock-in physician's name. If services are performed by an independent laboratory, enter the name of the referring physician.
17a	Unlabelled	**Situational** – If the recipient is linked to a Primary Care Physician, the 7-digit PCP referral authorization number is **required** to be entered.
17b	NPI	**Optional.**
18	Hospitalization Dates Related to Current Services	**Optional.**
19	Reserved for Local Use	Reserved for future use. Do not use.
20	Outside Lab?	**Optional.**
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.
22	Medicaid Resubmission Code	**Optional.**
23	Prior Authorization Number	**Situational** – Complete if appropriate or leave blank. If the services being billed must be Prior Authorized, the PA number is **required** to be entered.
24	Supplemental Information	**Situational** – Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product administered.** To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the **Qualifier N4** followed by the **NDC.** Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC. Providers should then leave one space then enter the appropriate **Unit Qualifier** (see below) and the **actual units administered.** Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space. The following qualifiers are to be used when reporting NDC units:

Locator #	Description	Instructions
		F2 International Unit ML Milliliter GR Gram UN Unit
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.
24C	EMG	**Situational** – Complete if appropriate or leave blank. When required, the appropriate CommunityCARE emergency indicator is to be entered in this field.
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s).
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.
24I	I.D. Qual.	**Optional.**
24J	Rendering Provider I.D. #	**Situational** – If appropriate, entering the Rendering Provider's Medicaid Provider Number in the shaded portion of the block is **required**. Entering the Rendering Provider's NPI in the non-shaded portion of the block is **optional**.
25	Federal Tax I.D. Number	**Optional.**

Locator #	Description	Instructions
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.
29	Amount Paid	**Situational** – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.
30	Balance Due	**Situational** – Enter the amount due after third party payment has been subtracted from the billed charges if payment has been made by a third party insurer.
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. **Required** -- Enter the date of the signature.
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.
32a	NPI	**Optional.**
32b	Unlabelled	**Situational** – Complete if appropriate or leave blank. When the billing provider is a CommunityCARE enrolled PCP, indicate the site number of the Service Location. The provider must enter the **Qualifier LU** followed by the **three digit site number**. Do not enter a space between the qualifier and site number (example "LU001", "LU002", etc.)
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.
33a	NPI	**Optional.**
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit Medicaid ID number.

ADJUSTING OR VOIDING CLAIMS

Incorrect claims payments may be adjusted or voided either electronically or hard copy.

- Only a paid claim can be adjusted or voided.
- Incorrect provider numbers and recipient Medicaid ID numbers cannot be adjusted. They must be voided, and then resubmitted.
- Complete the information on the adjustment form exactly as it appears on the original claim, changing only that item or items that were in error and giving the reasons for the changes in the space provided.
- To void a paid claim, enter all of the information from the original claim **exactly** as it appears on the original claim. After a voided claim has appeared on the Remittance Advice (RA), an original claim can be resubmitted giving all of the correct information that should appear on that claim.
- It is important to enter the correct Internal Control Number and Remittance Advice date from the paid claims in blocks 26 and 27 on the adjustment/void form. If this information is not entered exactly, the claim will deny with error message 799 (no history for this adjustment/void).
- When an Adjustment/Void form has been processed it will appear on the RA under **Adjusted or Voided Claims**. The adjustment or void will appear first. The original claim line will appear in the section directly beneath under the heading **Previously Paid Claims**.
- An Adjustment/Void will generate credit and debit entries that will appear in the Remittance Summary on the last page of the RA as "Adjusted Claims," "Previously Paid Claims" **or** "Voided Claims."

Electronic Adjustments/Voids

Adjustments and voids can be submitted electronically. If your present software installation does not offer this option, please contact your software vendor to discuss adding this capability to your software.

The same requirements that apply to hard copy adjustments/voids apply to electronic adjustments/voids.

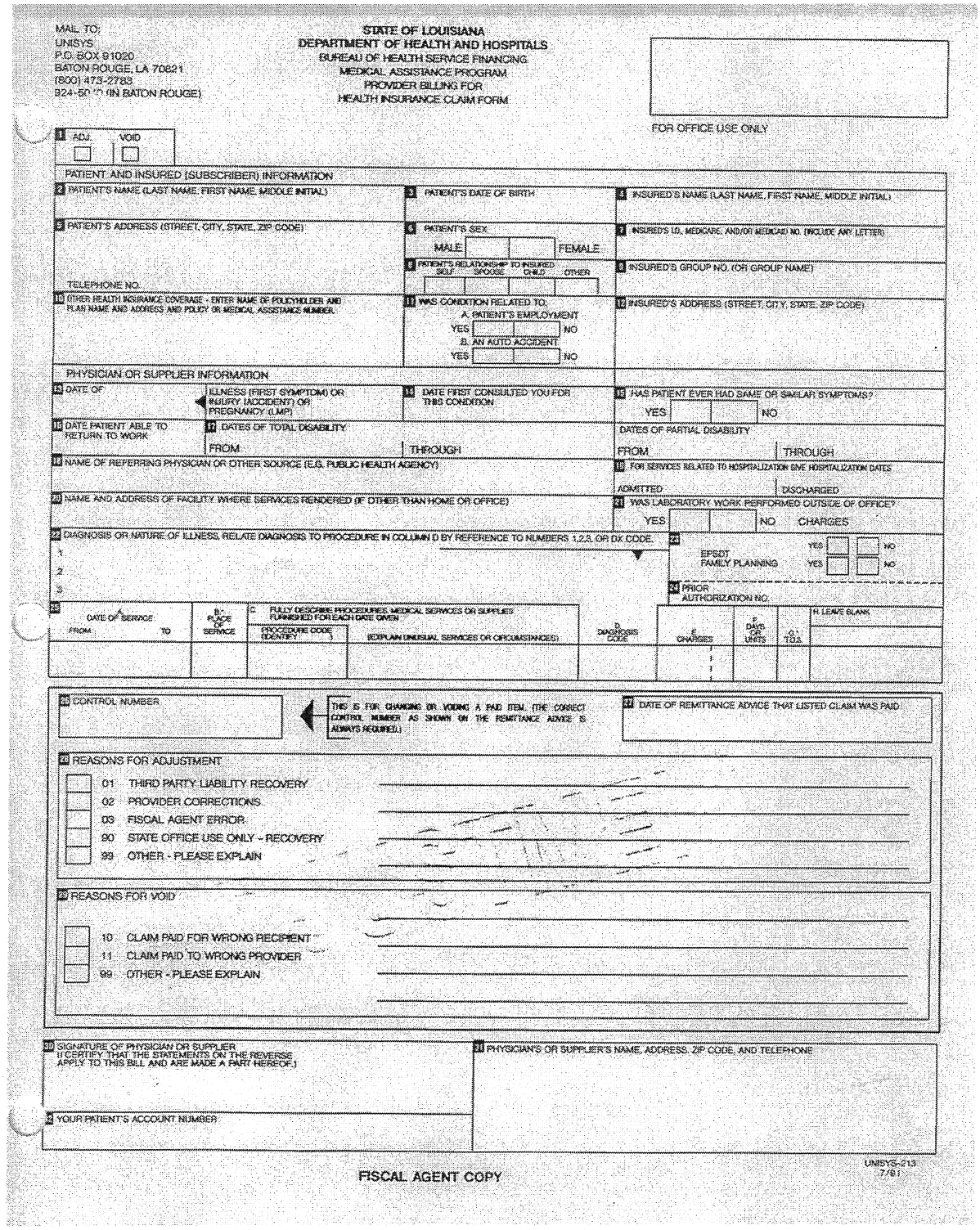
Hard Copy Adjustments and Voids

The 213 adjustment/void form is used for filing hard copy adjustments/voids. Completed Adjustment/Void forms should be mailed to the following address for processing:

Unisys
P.O. Box 91020
Baton Rouge, LA 70821

Only one (1) internal control number can be adjusted or voided on each 213 form.

213 Adjustment/Void Form Sample



MAIL TO:
UNISYS
P.O. BOX 91020
BATON ROUGE, LA 70821
(800) 473-2783
924-5011 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1 ADJ. VOID

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
3 PATIENT'S DATE OF BIRTH
4 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
5 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6 PATIENT'S SEX MALE FEMALE
7 INSURED'S I.D. MEDICARE AND/OR MEDICAID NO. (INCLUDE ANY LETTER)
8 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
9 INSURED'S GROUP NO. (OR GROUP NAME)
10 OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER.
11 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES NO
B. AN AUTO ACCIDENT YES NO
12 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14 DATE FIRST CONSULTED YOU FOR THIS CONDITION
15 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
16 DATE PATIENT ABLE TO RETURN TO WORK
17 DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G. PUBLIC HEALTH AGENCY)
19 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21 WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES NO CHARGES
22 DIAGNOSIS OR NATURE OF ILLNESS, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DK CODE.
1
2
3
23 EPSDT YES NO
FAMILY PLANNING YES NO
24 PRIOR AUTHORIZATION NO.

25 A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. T.O.S.	H. LEAVE BLANK

26 CONTROL NUMBER
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID

28 REASONS FOR ADJUSTMENT
- 01 THIRD PARTY LIABILITY RECOVERY
- 02 PROVIDER CORRECTIONS
- 03 FISCAL AGENT ERROR
- 90 STATE OFFICE USE ONLY - RECOVERY
- 99 OTHER - PLEASE EXPLAIN

29 REASONS FOR VOID
- 10 CLAIM PAID FOR WRONG RECIPIENT
- 11 CLAIM PAID TO WRONG PROVIDER
- 99 OTHER - PLEASE EXPLAIN

30 SIGNATURE OF PHYSICIAN OR SUPPLIER
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE
32 YOUR PATIENT'S ACCOUNT NUMBER

FISCAL AGENT COPY

UNISYS-213
7/91

Instructions for Completing the 213 Adjustment/Void Form

1.* **ADJ/VOID**—Check the appropriate block.

2.* **Patient's Name**

- **Adjust**—Print the name exactly as it appears on the original claim if not adjusting this information.
- **Void**—Print the name exactly as it appears on the original claim.

3. **Patient's Date of Birth**

- **Adjust**—Print the date exactly as it appears on the original claim if not adjusting this information.
- **Void**—Print the name exactly as it appears on the original claim.

4. **Medicaid ID Number**—Enter the 13 digit recipient ID number.

5. **Patient's Address and Telephone Number**

- **Adjust**—Print the address exactly as it appears on the original claim.
- **Void**—Print the address exactly as it appears on the original claim.

6. **Patient's Sex**

- **Adjust**—Print this information exactly as it appears on the original claim if not adjusting this information.
- **Void**—Print this information exactly as it appears on the original claim.

7.* **Insured's Name**— Leave this space blank.

8. **Patient's Relationship to Insured**—Leave this space blank.

9. **Insured's Group No.**—Complete if appropriate or leave space blank.

10. **Other Health Insurance Coverage**—Leave this space blank.

11. **Was Condition Related to:**—Leave this space blank.

12. **Insured's Address**—Leave this space blank.

13. **Date of:**—Leave this space blank.

14. **Date First Consulted You for This Condition**—Leave this space blank.

15. **Has Patient ever had same or Similar Symptoms**—Leave this space blank.

16. **Date Patient Able to Return to Work**—Leave this space blank.

17. **Dates of Total Disability-Dates of Partial Disability**—Leave this space blank.

18. **Name of Referring Physician or Other Source**—Leave this space blank.

19. **For Services Related to Hospitalization Give Hospitalization Dates**—Leave this space blank.

20. **Name and Address of Facility Where Services Rendered (if other than home or office)**—Leave this space blank.

21. **Was Laboratory Work Performed Outside of Office?**—Leave this space blank.

22.* **Diagnosis of Nature of Illness**

- **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.
- **Void**—Print the information exactly as it appears on the original claim.

23. **Attending Number**—Enter the attending number submitted on original claim, if any or leave this space blank.

24.* **Prior Authorization #**—Enter the PA number if applicable or leave blank.

25.* **A through F**

- **To Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.
- **To Void**—Print the information exactly as it appears on the original claim.

26.* **Control Number**—Print the correct Control Number as shown on the Remittance Advice.

27.* **Date of Remittance Advice that Listed Claim was Paid**—Enter MM DD YY from RA form.

28.* **Reasons for Adjustment**—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.

29.* **Reasons for Void**—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.

30.* **Signature of Physician or Supplier**—All Adjustment/Void forms **must** be signed.

31.* **Physician's or Supplier's Name, Address, Zip Code and Telephone Number**—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. ***The form will be returned if this information is not entered.***

32.* **Patient's Account Number**—(Optional) Enter the patient's correct provider-assigned account number.

Marked (*) items must be completed or form will be returned.

WHAT HAPPENS TO YOUR CLAIM?

When your claim is received in the mailroom, addressed to the proper Post Office Box for the claim type, it will be edited for missing data. If the signature, recipient Medicaid identification number, service dates, or provider name and/or number is missing the claim is rejected and returned to the provider.

Returned Claims

If the invoice is rejected because of missing or incomplete items, the original invoice you submitted will be returned to you accompanied by a return letter. The return letter will indicate why the invoice has been returned to you. A returned claim will not appear on the RA because it will not have entered the claims processing system. In addition, it will not be microfilmed and given a unique 13-digit Internal Control Number (ICN) before being returned to you.

Claims which have all the necessary items for claims processing completed proceed to the next part of the claims processing cycle, in which the claim is microfilmed, given an internal control number and are entered into the computer for processing.

Processed Claims

Claims that enter the processing system will be either approved (paid), pended or denied.

All claims that have been processed will fall into one of these three categories. You will receive an RA for each payment cycle in which you have claims processed.

TIMELY FILING GUIDELINES

To be reimbursed for services rendered, all providers must comply with the following filing limits set by the Medicaid Program.

- Straight Medicaid claims filed on the CMS-1500 must be filed within 12 months of the date of service.
- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare Fiscal Intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulation.
- Claims for recipients covered by Medicare and Medicaid (dual eligibility) must be billed to Medicare within 12 months of the date of service.
- Claims which fail to cross over via tape and have to be filed hard copy must be filed within six months of the date on the Medicare Explanation of Benefits in order to meet Medicaid timely filing regulations.
- Most dual eligible claims will crossover to Medicaid via tape and do not need to be filed hardcopy with the fiscal intermediary.
- Claims with third-party liability (TPL) payment must be filed within 12 months of the date of service. After receipt of payment from the TPL, the Medicaid claim must be filed ***hardcopy with an Explanation of Benefits (EOB) attached.***
- Claims denied by Medicare as non-covered that are covered by Medicaid will not be paid unless the claim is filed hardcopy with the Medicare EOMB attached stating the reason for denial by Medicare.

Medicaid will not pay a claim which has been denied by Medicare as not being medically necessary.

- Claims for recipients with retroactive coverage, e.g., spend-down medically needy claims, should be sent to the fiscal intermediary with a note of explanation AND a copy of Form 18-SSI (Medicaid Program Notice of Decision) or other official documentation from DHH indicating the recipient's retroactive status as soon as possible. The mailing address is as follows:

Unisys
Provider Relations
P. O. Box 91024
Baton Rouge, LA 70821

All claims for recipients with retroactive Medicaid coverage will be forwarded to BHSF for review and authorization.

Filing For Claims Exceeding The Timely Filing Limit

Medicaid claims received after the one (1) year maximum timely filing date cannot be processed unless the provider is able to furnish documentation of timely filing. This documentation must be legible and reference the individual recipient and the date of service. It may include:

A remittance advice (RA) indicating that the claim was processed within the original appropriate time frame:

OR

Correspondence received from either the state or parish Bureau of Health Services Financing office concerning the claim and/or the eligibility of the recipient.

Providers should ensure that the claim submitted with documentation is legible so that should the documentation uphold the request for an override of timely filing, that the claim can be successfully adjudicated.

Exception Requests for Claims Beyond the Two Year Timely Filing Limit

Claims that exceed two years from the date of service must be sent to the Bureau for review. The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend benefits of a hearing decision, corrective action or court order to other in the same situation as those directly affected by it.

- The recipient was certified for retroactive Medicaid benefits and the provider has filed the original claim within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits.
- The failure of the claim to pay was the fault of the Medicaid Program rather than the provider's fault each time the claim was adjudicated.
- The documentation of retroactive eligibility or your attempts to resolve the billing problems must be attached to the claim.

Tips On Timely Filing For Providers

- Providers must know how to bill correctly and how to resolve billing problems.
- Because of timely filing limitations, providers must make the necessary claim corrections within the timely filing limits. Re-filing a claim several times without correcting previously cited errors **IS NOT** considered a valid attempt to resolve a billing problem.

- All required items on the claim must be completed correctly.
- Providers are notified of claims that are denied for payment by the RA. A three (3)-digit error code designating the error is printed for each claim. These codes are listed with a brief explanation being given for each one on the RA that is on a separate page following the status listing of all claims. If you do not understand the process, contact Provider Relations, and someone will assist you with the matter.
- **Providers must make their own corrections. It is against regulations for the fiscal intermediary and/or DHH staff to make claim corrections for a provider.**
- The fiscal intermediary offers consultation for providers having problems billing correctly and/or resolving billing problems. **Contact Provider Relations at 1-800-473-2783 or (225) 924-5040.**

THIRD-PARTY LIABILITY (TPL)

Medicaid, by law, is intended to be the payor of last resort. Therefore, other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid recipient. When Medicaid is billed, the third-party carrier's Explanation of Benefits must be attached to the claim form.

If probable third party liability is established at the time the claim is filed, Medicaid will deny the claim and return it to the provider for determination of third party liability for most Medicaid services. There will be a carrier code number and listing made available to providers by the fiscal intermediary so that a claim can be submitted to the carrier by the provider. Also available to assist the provider with identifying the third party carrier are the MEVS and REVS systems.

If you find that the information regarding third party coverage provided is erroneous, it will be necessary for you to write to Provider Relations with a copy of the correspondence from the third party carrier. The fiscal intermediary will forward that correspondence to the Bureau for correction of the file.

If the carrier adjudicates the claim, then the provider must attach the EOB to a claim and resubmit the claim to the fiscal intermediary. If the carrier deems there is no coverage available then that claim and explanation should be sent to Provider Relations for file resolution, as stated above, prior to payment.

For recipients with Medicare coverage as well as Medicaid coverage, Medicaid will reimburse the provider an amount up to the full amount of the Medicare's statement of liability for co-insurance and deductible as long as it does not exceed Medicaid's allowable reimbursement for the service. Claims for which Medicare's reimbursement exceeds the maximum allowable by Medicaid, Medicaid will then "zero" pay the claim. This means that the claim will be shown in the Approved Claims section of the Remittance Advice and a "0" will be shown in the payment column. This claim is considered "payment in full" and the provider may not seek additional remuneration from the recipient.

MEDICARE/MEDICAID CROSSOVER PROCEDURES

Medicaid will pay the Medicare deductible and coinsurance on claims for non-QMB (Qualified Medicare Beneficiary) beneficiaries receiving both Medicare and Medicaid, provided the procedure is covered by the Louisiana Medicaid Program. For QMB beneficiaries, the Medicare deductible and coinsurance are paid even if the procedure is not in "pay" status.

If a patient has both Medicare and Medicaid coverage, providers should file claims in the appropriate manner with the regional Medicare Fiscal Intermediary/carrier, making sure they have included the beneficiary's Medicaid number on the Medicare claim form.

Once the Medicare intermediary/carrier has processed the Medicare portion of the core visit, the provider must send a hard copy claim to Unisys for co-insurance and deductible payment. To process hard copy Medicare crossover claims, the provider must do the following:

- Make a copy of the claim filed to Medicare
- Put the Medicaid provider number and recipient Medicaid number in the appropriate form locators
- Attach the Medicare EOB to the claim

The provide may submit a copy of the Medicare EOB providing the copy is legible. In addition, all of the EOB data, such as patient name and dates of service must match.

Medicare crossover claim should be sent to the following address for processing:

Unisys
P.O. Box 91023
Baton Rouge, LA 70821

Once a claim is received, the claim will be processed, and reimbursement for the deductible and coinsurance amounts will be made to the provider. Provider should receive the Medicaid payment four to six weeks after receiving the Medicare payment.

If a provider's Medicare/Medicaid claim does not appear on a Remittance Advice within six weeks of the Medicare date of pay, the claim has failed to crossover electronically and must be filed hardcopy.

RECOUPMENTS OF PAYMENTS

In situations where the third party resource payment is received after Medicaid has been billed and made payment, the provider must reimburse Medicaid. Reimbursement must be made immediately to comply with regulations. This refund mechanism is applicable to other claim situations in which an overpayment was made and a correction needs to be made. Use a void for claims less than two years old from the date of service.

Refunds should be made only in the case of claims more than two years old. Providers may reimburse Medicaid by forwarding a check; identify the claim or claims to which the refund is applied. The information necessary to identify these claims will help to reduce additional correspondence. This information can be found on the Remittance Advice (RA).

- Provider Number
- Date of Payment
- Control Number
- Recipient Name and Identification Number
- Date of Service
- Amount Paid
- Reason for Refund

Refunds should be made payable to the Department of Health and Hospitals and mailed to:

Payment Management Section
Bureau of Fiscal Services
Post Office Box 91117
Baton Rouge, LA. 70821-9117

THE REMITTANCE ADVICE

The purpose of the section is to familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the BHSF, and the fiscal intermediary. Aside from providing a record of transactions, the RA will assist providers in resolving and correcting possible errors and recording paid claims.

The Purpose Of The Remittance Advice

The RA is the control document that informs the provider of the current status of submitted claims – approved, pended, or denied. RAs are generated weekly for all providers who have claims processed during that weekly cycle and are mailed on Tuesdays of each week.

On the line immediately below each claim, a code will be printed representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. Approved original claims will not be accompanied by denial reason codes.

If you use a medical record number, (it may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

Approved Claims

Claims which are correctly completed when billing for a covered service provided to an eligible recipient/patient by an enrolled provider will be approved for payment and reimbursement will be made. It will appear on the RA on the first page or the page that lists all claims to be paid on the RA. If the payment is different from the billed charges, an explanation will appear on the RA via a 3-digit error code and an error message for that code will be found at the back of the RA.

Denied Claims

A claim will be denied for the following reasons:

- If the recipient is not eligible on the date of service
- If the provider is not enrolled on the date of service
- If prior authorization is required, but not reflected
- If the service is not covered by the program
- If the claim is a duplicate of a prior claim
- If the date is invalid or logically inconsistent; or
- If the program limitations are exceeded.

Three-digit message codes giving reason(s) for the denial will be printed on the line immediately following the claim information. An explanation of all codes appearing on the Remittance Advice will be printed on a separate page.

Pended Claims

Pended claims are those claims held for in-house review. If after the claim is reviewed, it is determined that a correction by the provider is required, the claim will be denied. If a resolution of the claim can be made, such as a data entry error and that can be corrected, then the claim will be sent on to payment.

Claims pend for many reasons. The following are a few examples:

- Errors were made in entering in the claims processing system.
- Errors were made in submitting the claim. Only the provider who submitted the claim can correct these errors.
- The internal Medical Review section must review the claim. Claims such as sterilization claims that require patient and physician signatures on the attachments are reviewed.
- Critical information is missing or incomplete. Remember, there are five fatal errors that cause a claim to be rejected before it enters the system but there are often common mistakes made in completing the claim form such as entering the wrong date of service or the wrong procedure code. These common errors are caught during the automated claims processing.

How To Check The Status Of A Claim-Control Number

A unique 13-digit number is given to each claim. The Control Number reflected on the RA can be used to track the status of your claims.

The first four digits of the Control Number are the actual year and day the claim was received. The next seven digits tell whether the claim is a paper claim or whether it was submitted on tape and what the batch and sequence numbers are which were entered into the processing system. All claim lines on a given claim form will have the same first 11 digits.

The last two digits of the Control Number will help you to determine which line of a claim form is being referenced:

Example: 3322023456700 – Refers to the first claim line
3322023456701 – Refers to the second claim line
3322023456702 – Refers to the third claim line

For those claim types that are not processed by line such as the hospital claim form (UB-92), the Control Number for the claim will always end in 00. All multiple-line claim forms with just one service billed on line 0 will also end in 00.

The unique 13-digit Control Number can be used to determine the status of claims for receipt to final adjudication.

Remittance Advice Copy And History Requests

Provider participation in the Louisiana Medicaid Program is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. One of those standards is the agreement to maintain any information regarding payments claimed by the provider for furnishing services for a period of five (5) years.

It is the responsibility of the provider to retain all RAs for five (5) years. However, if a provider requests copies of RA or Claim Histories, the fiscal intermediary will supply this information for a fee.

No fee will be charged in cases where the provider never received a check and RA.

Requests for RAs never received must be made within three (3) weeks of the RA date or there will be a charge for this information.

If providers are requesting RAs for multiple weeks or a large volume of RAs, the fiscal intermediary will determine whether RA copies or a claim history will be provided. Requests for RAs or Claims Histories may be made in writing to:

Unisys, Provider Relations,
P.O. Box 91024
Baton Rouge, LA 70821
Telephoning 1-800-473-2783 or (225) 924-5040

The provider name and number, address, date(s) of the RA being requested, and name of the individual requesting and authorizing the request must be included in the request.

Upon receipt of the request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/History will be forwarded to the provider once payment is received.

A fee of $0.25 per page, which includes postage, is charged to any provider who requests an additional copy of a Remittance Advice of one or more pages. Claims History fees may apply at the time of order.

OTHER PROGRAM LIMITATIONS

Some services may be provided to Medicaid recipients on an unlimited basis. Others, however, may be subject to certain program limitations. Provided in this subsection is a discussion of some of the services and limitations placed on the service.

Unlimited Services

Services for Recipients under the age of 21

These services include physician visits, either on an outpatient basis or an inpatient basis with some limits covered under the concurrent care policy explained in the Professional Services Manual. Home Health visits, emergency room visits subject to the prudent layperson definition, and antibiotic injections are all unlimited but subject to medical necessity. Preventative health services are covered only for persons under the age of 21. These services are subject to the programmatic guidelines established for the service and may be subject to prior authorization by Unisys or approval by the primary care physician (PCP) in the CommunityCARE program.

Exception: These unlimited services do not apply to foster care children who do not meet Medicaid eligibility standards by have claims processed through the fiscal intermediary.

Radiation Therapy or Chemotherapy for Malignant Diseases.

These services are unlimited regardless of age.

Dialysis Treatment

These services are unlimited and do not need a referral from a PCP in order to access the service.

Diagnostic Tests

Diagnostic tests ordered by the treating physician are unlimited when they are medically necessary. The program does not cover experimental and investigational tests not approved by the FDA. Duplicative tests with no inherent repetitive benefit are not covered.

Hospitalization

Hospitals are subject to having the stay of a recipient approved by Unisys Pre-Admission Review Unit. Stays for most illnesses are reviewed by diagnosis and given a length of stay. This is a computerized process and the utilization is considered within southern regional standards of care. If the patient must stay beyond that assigned length then the hospital is required to request an extension of the stay.

For psychiatric stays, either in a freestanding facility or a distinct part unit and Long Term Care stays in a hospital a pre-admission approval is necessary. Physicians and Nurses review medical data in order to determine whether the stay meets the published guidelines of the Bureau on what constitutes a reimbursable stay.

Transportation

Non-Emergency Medical Transportation usually by means of a car, a van, or Council on Aging vehicle requires authorization by Medical Dispatch Office. Trips without authorization from the Medical Dispatch Office will not be reimbursed.

Ambulance and Non-Emergency Ambulance Transportation means all trips in an ambulance. Ambulance transportation is authorized by the attending physician at the Emergency Room or by the treating physician at the place of service by completion of the appropriate form