PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Assistive Devices

OAAS Waivers

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION FOR PROVIDER ENROLLMENT

A Home Health Agency (PT-44) or a Durable Medical Equipment/DME (PT-40) provider may enroll simultaneously as an Assistive Devices (PT-17) provider for the Community Choices Waiver (CCW), and/or the Adult Day Health Care (ADHC) Waiver. All other providers will complete a basic enrollment packet to enroll as an Assistive Devices (PT-17) provider.

****NPI numbers are not required for Assistive Devices (PT-17) providers. If you do not submit an NPI number on your PE-50, you must submit claims using your Louisiana Medicaid provider number only. If you choose to submit an NPI number on your PE-50, please be aware that each Medicaid provider number is required to have a unique NPI number (different than the one for your HHA or DME file), so the Assistive Devices provider would need to obtain a new NPI number. Alternatively, the same NPI number can be used as another Medicaid provider number only if the NPI has multiple taxonomy codes listed; AND you list the applicable taxonomy code on your PE-50 in the Basic Enrollment Packet.**

The effective date for this enrollment will be the day the application is actually worked by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

Upon completion of the Medicaid enrollment process, all OAAS Waiver service providers and some providers of other Medicaid services will automatically be added to a Freedom of Choice listing in a web- based program called the Medicaid Provider Locator Tool. This enables public users to search for Medicaid and/or Home and Community-Based Services providers who accept Louisiana Medicaid.

If at any time during enrollment as an OAAS Waiver Medicaid provider, the provider has a change of physical address, the provider must first obtain an updated license indicating the new address. The provider must then submit notification of the change of address along with a copy of the new license to Gainwell Provider Enrollment Unit (See address on the checklist below.) Failure to report a change of address, first to Health Standards Section and then to Gainwell Provider Enrollment Unit, will result in your agency being incorrectly listed on the Freedom of Choice list.

NOTICE TO WAIVER SERVICE PROVIDERS

Please note that Louisiana Medicaid will only reimburse you for waiver services rendered to Medicaid recipients who are enrolled in a waiver program (Community Choices Waiver or Adult Day Health Care (ADHC) Waiver). Medicaid will not reimburse you for waiver services provided to recipients who are not enrolled in one of the waiver programs listed above.

Providers enrolled as type 17 (Assistive Devices) are allowed to provide services in accordance with applicable rules, regulations, and policies under the waiver programs as specified below:

- Assessment for and purchase of assistive technology, devices, & medical supplies by a Home Health Agency and/or a Durable Medical Equipment (DME) provider for OAAS Waiver recipients

GENERAL POLICY INFORMATION:

Waiver service providers are required to comply with both policy and program requirements located on the Louisiana Department of Health (LDH), Office of Aging and Adult Services (OAAS) website and in the Louisiana Medicaid provider manuals linked below.

Louisiana Medicaid Provider Manuals:
https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

LDH/OAAS website:
https://ldh.la.gov/index.cfm/subhome/12/n/7

OAAS Waivers - Assistive Devices

REQUIRED DOCUMENTS FOR ENROLLMENT

The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.

* Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

** Form is included in this packet.

	Document Name
☐ *	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. PE-50 Addendum – Provider Agreement Forms (three pages).
☐ *	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms.
☐ *	5. **(If submitting claims electronically)** Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable).
☐	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**).
☐	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**).
☐ **	8. Signed Existing Provider Information Form if currently enrolled as a Home Health Agency or DME Provider. (Only required for sub-specialty 3U & 4V).
☐ **	9. Notarized "*Provider Attestation for OAAS Community Choices Waiver Assistive Devices and Medical Supplies Services*" form.
☐	10. To report "Specialty" for this provider type on Section A of the PE-50, use Code 91 (Assistive Devices).
☐	11. To report "Sub-Specialty" as a <u>Home Health Agency provider</u> for the OAAS Waivers: CCW Assistive Devices and Medical Supplies and/or ADHC Waiver Activity and Sensor Monitoring on Section A of the PE-50, use Code 3U **<u>OR</u>** To report "Sub-Specialty" as a <u>DME provider</u> for the OAAS Waivers: CCW Assistive Devices and Medical Supplies and/or ADHC Waiver Activity and Sensor Monitoring on Section of the PE-50, use code 4V.
☐ **	12. " Provider Attestation for OAAS Waivers - Telecare Services Forms. (2 pages– **ONLY required if providing telecare services**.) Services allowed include procedure codes, S5160, S5161, S5160 NU U5, S9110 RR, S5160 U6, S5185 when providing and/or billing for Telecare Services.

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Provider Attestation for OAAS Waivers
CCW Assistive Devices and Medical Supplies and/or ADHC Waiver Activity and Sensor Monitoring Services

PURPOSE

This form confirms that the provider specified below wishes to provide Assistive Devices and Medical Supplies under the OAAS Community Choices Waiver(CCW) and/or Activity and Sensor Monitoring under the ADHC Waiver, and attests that the provider will conform to prior approval and reimbursement regulations and policies.

Provider Number:	LA Medicaid Provider # (Leave blank if new applicant)	National Provider Identifier (NPI)
Provider Name:		
Physical Address:		
Contact Person for questions regarding this form:		
Contact Person Phone Number:		

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are true and correct; and:

- That I can receive reimbursement for services provided only to those beneficiaries within the OAAS Community Choices Waiver and/or the OAAS ADHC Waiver;
- That the Medicaid OAAS Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare;
- That failure to exhaust these above referenced third party payer sources may subject this/my Medicaid enrolled agency to recoupment of funds previously paid by Medicaid;
- That all professional services provided to OAAS Waiver participants must be prior authorized before services are rendered; and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

Print Authorized Representative' Name | Signature of Authorized Representative | Date of Signature

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State of _____ on the _ day of _____, 20_.

Notary Seal or Notary Identification Number (required)

Notary Public Signature

Original Signatures Required – Please Do NOT Use Black Ink

EXISTING PROVIDER INFORMATION FORM

Please print name of the enrolling Assistive Devices provider agency: _____

List your Home Health Agency and/or Durable Medical Equipment provider numbers.

Provider Name	NPI	Provider Number

I understand and acknowledge the following NPI requirements:

****Each Medicaid provider number is required to have a unique NPI number (different than the one for your HHA or DME file), so the Assistive Devices provider will need to obtain a new NPI number. Alternatively, the same NPI can be used as another Medicaid provider number only if the NPI has multiple taxonomy codes listed and you list the applicable taxonomy code on your PE-50 in the Basic Enrollment Packet.**

Signature of Authorized Representative _____

Date of Signature _____

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Provider Attestation for OAAS Waivers - Telecare Services

This form confirms that the provider specified below agrees to provide Telecare services, through service codes S5160, S5161, S5160 NU U5, S9110 RR, S5160 U6, and S5185, through the OAAS Community Choices Waiver and/or the OAAS ADHC Waiver programs, and attests that the provider will conform to prior approval and reimbursement regulations and policies.

Provider Number:	LA Medicaid Provider # (Leave blank if new applicant)	National Provider Identifier (NPI)
Provider Name:		
Physical Address:		
Authorized Contact Representative:		
Authorized Contact Representative's Phone Number:		

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are true and correct; and I will be providing one or more of the following Telecare services listed below:

- **Activity and Sensor Monitoring (ADHC Waiver and CCW)** - Service will increase independence and access to health care; and reduce health care cost for the consumer. At a minimum the system will provide the information below:
  - Monitor home's points of egress;
  - Detect falls;
  - Detect movement and lack of movement;
  - Detect whether doors are opened or closed; and
  - Provide a push-button emergency alert system.

  Provide a monthly report to the Support Coordination Agency and OAAS.

- **Health Status Monitoring (CCW ONLY) -** Provide in home health-related data that will result in assessing the recipient's health condition and provide the recipient with pertinent information for improvement. At a minimum, the system will provide information on the recipient's:
  - Weight
  - Oxygen saturation measurements (pulse oximetry); and
  - Vital signs (pulse, blood pressure, etc.).

  Equipment must be capable of interfacing with the telecare health status monitoring equipment.
  Provide a monthly report to Support Coordination Agency and OAAS.

- **Medication Dispensing and Monitoring (CCW ONLY) -** This service assists the recipient by dispensing medication and monitoring medication compliance. At a minimum the system will provide the following:
  - Ability to dispense and monitor the recipient's medication compliance
  - Recipients compliance with medication therapy
  - Text or email notification when a missed dose or non-compliance occurs.

  Provide a monthly report on medication compliance to Support Coordination Agency and OAAS.

Provider Attestation for OAAS Waivers Telecare Services (continued)

Provider's Name: _____

I understand that I will provide services which comply with the following:

- Routine maintenance, replacement, and warranty for the specialized equipment.
- Monitoring of recipient-specific service by qualified staff will be provided 24 hours per day, 7 days per week.
- Training the recipient or recipient's responsible representative on the use of equipment.
- Remote training and coaching as necessary to the recipient and caregivers.

Reimbursement for Telecare services will be provided only to those authorized providers within the OAAS Waivers.

Finally, I understand that violation of this attestation shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

Print Authorized Representative's Name	Signature of Authorized Representative	Date of Signature

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State

Of _____ on the _____ day of _____, 20____.

_____
Notary Public Signature

Notary Seal or Notary Identification Number (required)

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370