LOUISIANA DEPARTMENT OF HEALTH

CHILDREN'S CHOICE WAIVER

Chapter Fourteen of the Medicaid Services Manual

Issued April 1, 2011

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

CHILDREN'S CHOICE WAIVER

TABLE OF CONTENTS

CHAPTER 14: CHILDREN'S CHOICE WAIVER

TABLE OF CONTENTS PAGE(S) 5

OVERVIEW

The Children's Choice (CC) Waiver is a Medicaid Home and Community-Based Services (HCBS) program that offers supplemental support to children with intellectual disabilities who currently live at home with their families, or who will leave an institution to return home. This waiver is unique in that it allows beneficiaries between the ages of birth through 20 years of age to receive a specified monetary amount annually in support services, including support coordination, within a service package individually designed for maximum flexibility. This waiver is an optional service that will be offered to as many children as funding allows. This waiver is operated by the Office for Citizens with Developmental Disabilities (OCDD) under the authorization of the Bureau of Health Services Financing (BHSF). Both OCDD and BHSF are agencies within the Louisiana Department of Health (LDH).

Support services to be provided are specified in the plan of care (POC). The person-centered planning team, including support coordinators, service providers, family/guardians, and those who know the child best, develops this plan. The POC contains all services and activities involving the beneficiary, including non-waiver services as well as waiver support services. This waiver includes center-based respite, family support, environmental accessibility adaptations, support coordination, specialized medical equipment and supplies, aquatic therapy, art therapy, music therapy, sensory integration, hippotherapy/therapeutic horseback riding, housing stabilization services, housing stabilization transition services and family training. These services are provided as a supplement to all other medically necessary Medicaid services. Beneficiaries receive only those support services included in the POC which are approved by the local Human Services Authority or District.

Providers are responsible for complying with the requirements in Chapter 1, "General Information and Administration Provider Manual" of the Medicaid Services Manual. This manual is available on the Louisiana Medicaid website under the "Provider Manuals" tab. www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

Beneficiaries have the choice of available support coordination and service provider agencies and are able to select enrolled qualified agencies through the freedom of choice (FOC) process. Beneficiaries also have the right to request changes to the staff that support them. CC Waiver services are accessed through the beneficiary's support coordinator and are based on the individual needs and preferences of the beneficiary. A support team, which consists of the beneficiary, support coordinator, beneficiary's authorized representative, appropriate professionals/service providers, and others whom the beneficiary chooses, is established to develop the beneficiary's POC through a person centered planning process. The POC contains all services and activities involving the beneficiary, including non-waiver services as well as waiver support services. The completed POC is submitted to the Support Coordination Agency (SCA) supervisor or Human

Services Authority or District office for review and approval as designated in OCDD policy. All POCs approved by the SCA supervisor shall be submitted to the Human Services Authority or District office.

The Medicaid data contractor is responsible for the management of prior and post authorization of waiver services based on the information included in the approved POC and entered into the service provider data collection system. The LDH fiscal intermediary (FI) maintains a computerized claims processing system, with an extensive system of edits and audits, for payment of claims to providers.

NOTE: While the following settings are appropriate for HCBS services, minor children are subject to parental authority:

1. Participants receiving any CC services are expected to be integrated in and have full access to the greater community while receiving services, as well as have opportunities to seek employment and work in competitive integrated settings. Additionally, participants have the right to control their personal resources, engage in community life, and receive services in the community to the same degree of access as individuals not receiving HCBS;

2. The setting is selected by the participant from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;

3. The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint, including the right to respectful interactions and privacy in both residential and non-residential settings;

4. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact;

5. Participants have choice regarding services and supports, and who provides them;

6. Participants can control their own schedule and activities, including access to food at any time to the same extent as individuals who are not receiving Medicaid HCBS;

7. Participants are able to have visitors of their choosing at any time to the same extent as individuals who are not receiving Medicaid HCBS;

8. The setting where services are provided must be physically accessible to the individual such that all areas of normal access are not restricted; and

9. Residential settings owned or controlled by the provider must also meet the following requirements:

    a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

    b. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. Individuals in provider owned or controlled residential settings shall have privacy in their living or sleeping unit;

    c. Individuals sharing units have a choice of roommates in that setting; and

    d. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

This chapter specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of federal and state laws and LDH policy that provide support to such individuals.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services, and proper fund disbursement. Should a conflict exist between chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This chapter is intended to give a CC provider the information needed to fulfill its vendor contract with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and LDH rules.

OCDD is responsible for assuring provider compliance with regulations of this waiver. The LDH Health Standards Section (HSS) determines compliance with state licensing requirements for respite and family support services under the definition of this waiver.

COVERED SERVICES

The array of services described below is provided under Louisiana Children's Choice (CC) Waiver program in accordance with the plan of care (POC), in addition to all regular Medicaid State Plan services. This person-centered plan is designed cooperatively by the support coordinator, the beneficiary, and members of the beneficiary's support network, which may include family members, service providers, appropriate professionals, and other individuals who best know the beneficiary. The POC should include all paid and unpaid services that are necessary to support the beneficiary in their home and promote greater independence.

Beneficiaries must receive at least one CC waiver service every 30 days. The cost of waiver services, including support coordination and the administrative fees for the self-direction option, if selected, cannot exceed the annual service cap. (See Appendix E for service cap and rate information). Within the annual service cap, the beneficiary and family, together with the support coordinator, will have the flexibility within the scope of the waiver to select the type and amount of services consistent with the beneficiary's health and welfare needs. This annual cap refers to the cost of approved services provided during the 12-month period addressed in the beneficiary's POC. This limit is not defined by waiver, calendar, or state fiscal year (SFY), but rather by the specific 12-month period during which the approved POC is in effect. Should the POC be amended during the 12-month period, the annual service cap continues to apply for the duration of the original 12 months.

CC services may be utilized to supplement Early and Periodic Diagnostic, Screening and Treatment (EPSDT) services that are prior approved as medically necessary.

CC services cannot be provided in a school setting. Services provided through a program funded under the Individuals with Disabilities Education Act (IDEA) must be utilized before accessing CC therapy services.

Support Coordination

Support coordination consists of the coordination of supports and services that will assist beneficiaries who receive CC waiver services in gaining access to needed waiver and Medicaid services, as well as other needed medical, social, educational and other services, regardless of the funding source. Beneficiaries/families choose a support coordination agency through the Freedom of Choice (FOC) listing provided by the Medicaid data contractor upon acceptance of a waiver opportunity. The support coordinator is responsible for convening the person-centered planning team comprised of the beneficiary, beneficiary's family, direct service providers (DSPs), medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies to meet the beneficiary's needs and preferences. The support

coordinator shall be responsible for the ongoing coordination and monitoring of supports and services included in the beneficiary's POC.

Family Support Services

Family support services are defined as direct support and assistance provided to a beneficiary in their home or in the community that allow the beneficiary to achieve and/or maintain increased independence, productivity, enhanced family functioning, and inclusion in the community to the same degree as individuals without disabilities. These services are provided by a personal care attendant and enable a family to keep their child or family member with a developmental disability at home. Services may be provided in the child's home or outside of the child's home in such settings as after school programs, summer camps, or other settings as specified in the approved POC. Family support services may not be provided in the following locations:

1. Direct service worker's (DSW's) residence, regardless of the relationship, unless the worker's residence is a certified foster care home;

2. Hospital once the beneficiary has been admitted;

3. Licensed congregate setting which includes licensed intermediate care facilities for the Intellectually Disabled (ICFs/IID), community homes, center-based respite facilities and day habilitation programs;

4. Outside the state of Louisiana, but within the United States or its territories, unless there is a documented emergency or a time-limited exception which has been prior approved by the local governing entity (LGE) and included in the beneficiary's POC; or

5. Outside the United States or territories of the United States.

Family support services include assistance and/or prompting with eating, bathing, dressing, personal hygiene, and essential housekeeping incidental to the care of the child. Housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the child rather than the beneficiary's family may be provided. Services may be provided without the parent or legal guardian present. This service may include assistance with the preparation of the beneficiary's meals, but does not include the cost of the meals themselves. Medication may only be administered when the DSW has received the required training pursuant to R.S. 37:1031-1034.

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

Family members who provide family support services must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant. Service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by each staff living in the home.

Legally responsible individuals (such as a parent or spouse) and legal guardians may provide family support services for their own child, provided that the care is extraordinary in comparison to that of a child of the same age without a disability and the care is in the best interest of the child. Legally responsible individuals and legal guardians may not provide family support services delivered through self-direction.

NOTE: The provider is not allowed to charge the beneficiary, their family member or others a separate fee for transportation, as transportation is included in the rate paid to the DSP with no specified mileage limit.

Personal care attendant provider agencies must meet state licensure requirements.

NOTE: CC family support services may be performed the same day as EPSDT personal care services (PCS) but not at the same time. When this occurs, records must reflect the services performed in a detailed manner for monitoring purposes. Family support service requires prior authorization (PA) from the Office for Citizens with Developmental Disabilities (OCDD). PCS is prior authorized by the Medicaid fiscal intermediary (FI). (See Appendix D for information about differences between these programs).

CC family support services cannot be provided on the same day at the same time as any other CC waiver service except for the following:

1. Environmental accessibility adaptations;
2. Family training;
3. Specialized medical equipment and supplies; or
4. Support coordination.

The use of the electronic visit verification (EVV) system is mandatory for family support services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OCDD.

Center-Based Respite Care

Center-based respite care is a service provided to beneficiaries unable to care for themselves, and is furnished on a temporary/short-term basis due to the absence or need for relief of those persons normally providing the care (e.g., sudden emergencies, vacations, etc.). This service must be provided in a licensed home and community-based services (HCBS) center-based respite care facility according to the HCBS Provider's Minimum Licensing Standards. Services are provided according to a POC that takes into consideration the specific needs of the person.

Center-based respite care shall not exceed 30 consecutive days without approval by OCDD.

Environmental Accessibility Adaptations

Environmental accessibility adaptations are physical adaptations to the home or vehicle. They are provided when required by the beneficiary's POC, as necessary to assure the health, safety and welfare of the beneficiary or which enable the beneficiary to function with greater independence in the community, and without which the beneficiary would require additional supports or institutionalization.

Adaptations to the home may include:

1. Installation of ramps (portable or fixed);
2. Grab-bars;
3. Handrails;
4. Widening of doorways;
5. Modification of bathroom facilities, which are necessary for the health and welfare of the beneficiary; or
6. Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the beneficiary.

Adaptations to the vehicle may include the following:

1. Van lift; or
2. Other adaptations to make the vehicle accessible to the beneficiary.

All environmental accessibility adaptation providers must be registered through the Louisiana State Licensing Board for Contractors as a home improvement contractor, with the exception of providers of vehicle adaptations. When required by state law, the person performing the service, such as building contractors, plumbers, electricians, or engineers, must meet applicable requirements for professional licensure and modifications to the home and all applicable building code standards.

Providers of environmental accessibility adaptations to vehicles must be licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.

The following are excluded:

1. Adaptations which add to the total square footage of the home;

2. Purchase or lease of a vehicle;

3. Regularly scheduled upkeep and maintenance of a vehicle (except upkeep and maintenance of the vehicle modification);

4. Adaptations to a vehicle that belongs to someone other than the beneficiary or the beneficiary's family;

5. Car seats;

6. Adaptations or improvements to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the beneficiary, such as:

    a. Flooring (carpeting, wood, vinyl, tile, stone, marble, etc.);

    b. Roof repair;

    c. Interior or exterior walls not directly affected by an adaptation;

    d. Central air conditioning; or

    e. Fences; etc.

7. Fire alarms, smoke detectors, and fire extinguishers; and

8. Whole home electrical generators.

Home modification funds are not intended to cover basic construction costs. For example, in a new facility, a bathroom is already part of the building cost. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

A written, itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted for PA.

It is the support coordinator's responsibility to include environmental accessibility adaptations in the POC or a POC revision request if this service is needed and requested by the beneficiary/family.

The support coordinator must assist the beneficiary in completing the Environmental Accessibility Adaptation Job Completion form and any other associated documentation to request PA. (See Appendix D for information on obtaining a copy of this form). The LGE must approve the request, prior to any work being initiated.

The environmental accessibility adaptation(s), whether from an original claim, corrected claim, resubmit or revision to the POC, must be accepted by the beneficiary/authorized representative, fully delivered, installed, operational, and completed in the current POC year in which it was approved. Payment will not be authorized until the support coordinator has received written documentation that demonstrates the job is completed to the satisfaction of the beneficiary.

Upon completion of the work and prior to payment, the provider must give the beneficiary a certificate of warranty for all labor and installation, and all warranty certificates from manufacturers. The warranty for labor and installation must cover a period of at least six months.

Excluded are those durable and non-durable items that are available under the Medicaid State Plan. Support coordinators must pursue and document all alternate funding sources that are available to the beneficiary before submitting a request for approval to purchase an environmental accessible adaptation. To avoid delays in service provisions/implementation, the support coordinator should be familiar with the process for obtaining durable medical equipment (DME) through the Medicaid State Plan.

Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies are devices, controls, or appliances, as specified in the POC, that enable beneficiaries to increase their abilities to perform activities of daily living (ADL), or to perceive, control, or communicate with the environment in which they live. This also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. The provider must be enrolled as a Medicaid waiver provider.

Technology Supports with Remote Features

The Medication Reminder System (MERS) is an electronic device programmed to remind the individual to take medications by a ring, automated recording or other alarm. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser. Medications must be set up by a registered nurse (RN) in the absence of a parent or authorized representative. An RN must fill a pillbox unless there is a parent or guardian that can fill it. Other equipment used to support someone remotely may include: electronic motion door sensor devices, door alarms, web-cams utilized in a Health Insurance Portability and Accountability Act (HIPAA) compliant manner that assure privacy, telephones with modifications (large buttons, flashing lights), devices affixed to wheelchair or walker to send alert when fall occurs, text-to-speech software, intercom systems, tablets with features to promote communication or smart device speakers.

Remote Technology Service Delivery covers monthly response center/remote support monitoring fee and tech upkeep (no internet cost coverage).

Remote Technology Consultation the evaluation of tech support needs for an individual, including functional evaluation of technology available to address the person's access needs and support person to achieve outcomes identified in the POC.

Specialized medical equipment and supplies may be used for routine maintenance or repair of specialized equipment such as:

1. Sip and puffer switches;

2. Other specialized switches; and

3. Voice-activated, light-activated, or motion-activated devices to access the beneficiary's environment.

Excluded are those specialized equipment and supplies that are not of direct medical or remedial benefit to the beneficiary such as, but not limited to the following:

1. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.);

2. Swimming pools, hot tubs, etc.;

3. Personal computers and software;

4. Daily hygiene products;

5. Rent subsidy;
6. Food;
7. Bed linens (pillows, sheets, etc.);
8. Exercise equipment, athletic shoes;
9. Adaptive toys, recreation equipment (swing set, etc.);
10. Taxi fares, bus passes (intrastate or interstate), etc.;
11. Pagers and telephones, including monthly service;
12. Home security systems, including monthly service;
13. Durable and non-durable items available under the Medicaid State Plan; and
14. Whole home electrical generators.

All items must meet applicable requirements for manufacturing, design and installation of technological equipment and supplies.

The support coordinator must pursue and document all alternate funding sources that are available to the beneficiary before submitting a request for approval to purchase or lease specialized medical equipment and supplies.

Family Training

Family training consists of formal instruction offered through training and education for the families of beneficiaries served by the CC Waiver. This training and education must be conducted by professional organizations or practitioners who offer education or training appropriate to the needs of the child. For purposes of this service only, "family" is defined as persons who live with or provide care to a beneficiary in by the CC Waiver and may include a parent, step-parent, grandparent, sibling, legal guardian, spouse, in-law or foster family.

Family training must be prior approved and incorporated in the POC. Requests for this service must be made on the Family Training request form. (See Appendix D for information on obtaining a copy of this form).

Payment for family training services includes coverage of registration and training fees associated with formal instruction in areas relevant to the beneficiary's needs as identified in the POC. Payment is not available for the costs of travel, meals and overnight lodging to attend a training event or conference or for the beneficiary to attend the training.

All services provided through programs funded under IDEA [20 U.S.C. 1401 *et seq*.] must be utilized before accessing this service.

Professional Services Providers

Professional services are direct services to beneficiaries based on need that may be utilized to increase the beneficiary's independence, participation and productivity in the home and community. Service intensity, frequency and duration will be determined by individual need. Professional services include the following:

1. Aquatic therapy;
2. Art therapy;
3. Music therapy;
4. Sensory integration; and
5. Hippotherapy/therapeutic horseback riding.

State Plan services must be accessed prior to professional services in this waiver. Professional services must be delivered with the beneficiary present and in accordance with the POC.

Providers of professional services must maintain adequate documentation to support service delivery and compliance with the approved POC. Documentation must be available at the Louisiana Department of Health's (LDH's) request.

Aquatic Therapy

Aquatic therapy uses the resistance of water to rehabilitate a beneficiary with:

1. A chronic illness;
2. Poor/lack of muscle tone; or
3. A physical injury/disability.

Aquatic therapy should not be used when a beneficiary is feverish, has an infection, or is bowel/bladder incontinent.

Art Therapy

Art therapy is used to:

1. Increase awareness of self and others;
2. Cope with symptoms, stress and traumatic experiences;
3. Enhance cognitive abilities; and
4. As a mode of communication and enjoyment of the life-affirming pleasure of making art.

Art therapy may be provided individually or with others in groups of two to three or in groups of four or more individuals per session.

Music Therapy

Music therapy is used to help beneficiaries improve their cognitive functioning, motor skills, emotional and affective development, behavior and social skills and their quality of life. Music therapy may be provided individually or with others in groups of two to three or in groups of four or more individuals per session.

Sensory Integration

Sensory integration is used to improve the way the brain processes and adapts to sensory information as opposed to teaching specific skills. Sensory integration involves activities that provide vestibular (balance/motion), proprioceptive (visual/sight) and tactile (touch) stimuli which are selected to match specific sensory processing deficits of the beneficiary.

Hippotherapy/Therapeutic Horseback Riding

Hippotherapy/therapeutic horseback riding is used to promote the use of the movement of the horse as a treatment strategy in physical, occupational and speech-language therapy sessions for people living with disabilities. The movement of the horse provides physical and sensory input which is variable, rhythmic and repetitive. Equine movement coerces the beneficiary to use muscles and body systems in response to movement of the horse.

Hippotherapy

Hippotherapy improves muscle tone, balance, posture, coordination, motor development as well as motor planning that can be used to improve sensory integration and attention skills. Hippotherapy must be ordered by a physician with implementation of service, treatment strategies and goals developed by a licensed therapist. Services must be included in the beneficiary's POC.

Specially trained therapy professionals evaluate each potential beneficiary on an individual basis to determine the appropriateness of including hippotherapy as a treatment strategy. Hippotherapy sessions are one-on-one with a licensed physical therapist, speech therapist or occupational therapist who works closely with the horse professional in developing treatment strategies.

The licensed therapist must be present during the hippotherapy sessions.

Therapeutic Horseback Riding

Therapeutic horseback riding teaches riding skills and improves neurological function and sensory processing. Therapeutic horseback riding must be ordered by a physician with implementation of service, treatment strategies and goals developed by a licensed therapist. Services must be included in the beneficiary's POC.

Therapeutic horseback riding therapy sessions do not require the licensed therapist to be present during the session and may be provided one-on-one or in groups up to four individuals per session.

Housing Stabilization Transition and Housing Stabilization Services

Housing stabilization transition and housing stabilization services are provided by permanent supportive housing agencies that are listed as a provider of choice on the FOC form. These services are only available upon referral from the support coordinator for beneficiaries who are residing in a state of Louisiana permanent supportive housing unit, or who are linked for the state of Louisiana permanent supportive housing selection process.

These services are not duplicative of other waiver services, including support coordination. Beneficiaries may not exceed a combination of 165 units of housing stabilization transition and housing stabilization services per POC year without written approval from OCDD.

NOTE: Payment will not be authorized for these services until the LGE gives final POC approval.

Housing Stabilization Transition Services

Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their

own housing. This service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. This service includes the following components:

1. Conducting a housing assessment to identify the beneficiary's preferences related to housing (e.g., type, location, living alone or with someone else, accommodations needed, and other important preferences), and their needs for support to maintain housing, including:

    a. Access to housing;

    b. Meeting the terms of a lease;

    c. Eviction prevention;

    d. Budgeting for housing/living expenses;

    e. Obtaining/accessing sources of income necessary for rent;

    f. Home management;

    g. Establishing credit; and

    h. Understanding and meeting the obligations of tenancy as defined in the lease terms.

2. Assisting the beneficiary to view and secure housing as needed, which may include arranging for and providing transportation;

3. Assisting the beneficiary to secure supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

4. Developing an individualized housing support plan based upon the housing assessment that:

    a. Includes short and long term measurable goals for each issue;

    b. Establishes the beneficiary's approach to meeting the goal; and

    c. Identifies where other provider(s) or services may be required to meet the goal.

5. Participating in the development of the POC and incorporating elements of the housing support plan; and

6. Exploring alternatives to housing if permanent supportive housing is unavailable to support completion of the transition.

Housing Stabilization Services

Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in the beneficiary's approved POC. Services must be provided in the home or a community setting. This service includes the following components:

1. Conducting a housing assessment to identify the beneficiary's preferences related to housing (e.g., type, location, living alone or with someone else, accommodations needed, and other important preferences), and their needs for support to maintain housing, including:

    a. Access to housing;

    b. Meeting the terms of a lease;

    c. Eviction prevention;

    d. Budgeting for housing/living expenses;

    e. Obtaining/accessing sources of income necessary for rent;

    f. Home management;

    g. Establishing credit; and

    h. Understanding and meeting the obligations of tenancy as defined in the lease terms.

2. Participating in the development of the POC and incorporating elements of the housing support plan;

3. Developing an individualized housing stabilization service provider plan based upon the housing assessment that:

    a. Includes short and long term measurable goals for each issue;

b. Establishes the beneficiary's approach to meeting the goal; and

c. Identifies where other provider(s) or services may be required to meet the goal.

4. Providing supports and interventions according to the individualized housing support plan;

5. Providing ongoing communication with the landlord or property manager regarding the beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager;

6. Updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status; and

7. Providing supports to retain housing or locate and secure housing to continue community-based supports if the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income). This includes locating new housing, sources of income, etc.

Crisis and Non-Crisis Provisions

Crisis Provision

A crisis is defined as a catastrophic change in circumstances rendering the natural and community support system unable to provide for the health and welfare of the child at the level of benefits offered under the CC program. Crisis designation is time limited, depending on the anticipated duration of the causative event. Each request for crisis designation may be approved for a maximum of three months or until the annual POC date, not to exceed 12 months. To be considered a crisis, one of the following must apply:

1. Caregiver dies and there are no other supports (i.e., other family) available;

2. Caregiver becomes incapacitated and there are no other supports (i.e., other family) available;

3. Child is committed by court to the custody of LDH;

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

5. Physician's documentation of deterioration of the child's condition to the point the POC is inadequate.

NOTE: The CC Waiver has an annual capped amount. Therefore, planning is crucial in determining the services the family chooses to access during the POC year. **Use of all the funds for a planned service (e.g. Environmental Accessibility Adaptation, etc.) does not constitute a crisis designation request to exceed the annual service cap for other services the family needs for the remaining POC year.**

Process for Determining Qualification for Crisis Designation

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

The support coordinator is required to exhaust all possible natural and community supports and resources available to the child and family prior to submitting a Request for Crisis Designation form to the LGE and submit supporting documentation that resources were researched and unable to be utilized. (See Appendix D for information on obtaining a copy of this form). The support coordinator will contact the LGE for intervention.

If it is determined that there are insufficient natural or community supports available, the support coordinator will complete the "Request for Crisis Designation" form and supporting documentation and submit to the LGE for priority consideration and recommendation. A POC revision must accompany the request for crisis supports, with resource exploration and availability as well as a financial assistance summary attached.

The LGE will:

1. Review the request immediately upon receipt to determine if all possible natural and community resources have been explored;

2. Determine if a new North Carolina – Support Needs Assessment (NC-SNAP) or Health Risk Assessment Tool (HRST) is needed;

3. Make a recommendation regarding support(s) needed and the expected duration of the crisis; and

4. Forward the "Request for Crisis Designation" form and supporting documentation to OCDD for final determination.

OCDD will take the following action:

1. Review the request and the LGE's recommendations;

2. Make a final determination within 48 hours (two business days) of receipt; and

3. Notify the LGE of the determination.

Provisions of a Crisis Designation

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

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

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

Eligibility and services through CC shall continue as long as the child meets eligibility criteria.

Non-Crisis Provision

Determining Non-Crisis Designation

In addition to satisfying crisis provisions, a beneficiary may also be allowed to restore their name to the RFSR in original date order in a "non-crisis provision - other good cause criteria" when all of the following four criteria are met:

1. Beneficiary would benefit from services, that are available through another developmental disabilities waiver, which are not available through their current waiver or through Medicaid State Plan Services;

2. Beneficiary would qualify for those services, under the standards utilized for approving and denying services to the developmental disabilities waiver beneficiaries;

3. There has been a change in circumstances, since their enrollment in the Louisiana

CC waiver causing these other services to be more appropriate. A change in the beneficiary's medical condition is not required. A change in circumstance can include the loss of in-home assistance through a caretaker's decision to take on or increase employment, or to obtain education or training for employment. The temporary absence of a caretaker due to a vacation is not considered "good cause"; and

4. The person's request date for the developmental disabilities waiver has been passed on the RFSR.

Adding the beneficiary back to the RFSR will allow them to be placed in the next available waiver slot that will provide the appropriate services provided the beneficiary is still eligible when the slot is available.

A beneficiary's being added back to the RFSR does not require that LDH immediately offer them a waiver slot if all slots are filled. It does not require that LDH make available to this beneficiary a slot for which another beneficiary is being evaluated even if the other beneficiary was originally placed on the RFSR on a later date.

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

If another developmental disability waiver would provide the beneficiary with the services at issue, LDH may enroll the beneficiary in any waiver that would provide the appropriate services as referenced in criteria for non-crisis provision/other good cause.

If a CC beneficiary's eligibility is terminated based on inability to assure health and welfare of the waiver beneficiary, LDH will restore the person to the RFSR for the developmental disabilities waiver in their original date order.

Under regulations and procedures applicable to Medicaid fair hearings, CC beneficiaries have the right to appeal any determination of LDH as set forth in the non-crisis provisions.

Process for Non-Crisis/Other Good Cause Designation

The family contacts the support coordinator who convenes the person-centered planning team to establish non-crisis designation and address the change in needs. The support coordinator will contact the LGE for intervention. If it is determined that a non-crisis/other good cause has been fulfilled, the support coordinator will complete the Request for Non-Crisis/Other Good Cause form and submit it with supporting documentation to the LGE for consideration and recommendation. (See Appendix D for information on obtaining a copy of this form). A POC revision must accompany the request for non-crisis/other good cause provision.

The LGE will:

1. Review the request to determine that all four of the criteria have been met;

2. Make a recommendation; and

3. Forward the request form, with any supporting documentation to OCDD for final determination.

OCDD will take the following action:

1. Review the request, the LGE's recommendations and any supporting documentation;

2. Make a final determination as to whether the individual's name will be returned to the Developmental Disability Request for Services Registry (DDRFSR); and

3. Notify the LGE of the recommendations.

BENEFICIARY REQUIREMENTS

The Louisiana Children's Choice (CC) Waiver is only available to children who meet, and continue to meet, all of the following criteria:

1. Are from birth through age 20 years;

2. Have their name on the Request for Services Registry (RFSR);

3. Meet the Developmental Disability Law criteria as defined in Appendix A;

4. Meet the following financial and non-financial Medicaid eligibility criteria for home and community-based services (HCBS) waiver:

    a. Income is less than three times the Supplemental Security Income (SSI) amount for the child (excluding consideration of parental income);

    b. Resources are less than the SSI resource limit of $2,000 for a child (excluding consideration of parental resources);

    c. SSI disability criteria; and

    d. Social security number (SSN).

5. Meet the intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care (LOC) criteria which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;

6. Meet citizenship requirement (U.S. citizen or qualified alien);

7. Be a Louisiana resident;

8. Have a plan of care (POC) that is sufficient to assure the health and welfare of the waiver applicant in order to be approved for waiver participation or continued participation; and

9. Justification in the POC that CC Waiver services are appropriate, cost effective, and represent the least restrictive environment for the beneficiary.

Children who reach their 18th birthday may choose to transition to the Supports Waiver (SW) if their primary goal is employment. Children who reach their 21st birthday while participating in

the CC Waiver will transition into an appropriate adult waiver as long as they remain eligible for waiver services.

Developmental Disabilities Request for Services Registry

Enrollment in CC Waiver services is dependent upon the number of approved and available funded waiver slots. Requests for waiver services are made through the applicant's local governing entity (LGE). Individuals who request waiver services are placed on a statewide RFSR and are selected for an Office of Citizens with Developmental Disabilities (OCDD) waiver opportunity based on their urgency of need and earliest registry date. Only requests from the applicant or their authorized representative will be accepted.

Once it has been determined by the LGE that the applicant meets the definition of a developmental disability as defined by the Louisiana Developmental Disability Law (See Appendix A), the applicant's name will be placed on the RFSR in request date order and the applicant/family will be sent a letter stating the individual's name has been secured on the RFSR along with the original request (protected) date. The individual will then undergo a screening for urgency of need (SUN). Entry into an OCDD waiver will be offered to applicants from the RFSR by urgency of need and the earliest request for services date.

Verifying Screening for Urgency of Need and Request Date

Applicants or their authorized representatives may verify their SUN score and request date by calling their LGE. (See Appendix C of this manual chapter).

Medical Certification Eligibility Requirements

Each applicant must meet a separate categorical requirement of disability as defined by the Social Security Administration (SSA). If the applicant does not receive SSI, a disability determination is required as part of the eligibility process. The support coordinator will submit medical information to the Bureau of Health Services Financing (BHSF). The disability determination is made by the BHSF medical eligibility determination team and ***is separate*** from the LOC determination made by the LGE for waiver service eligibility.

Application Process

A Medicaid eligibility application must be completed for all waiver applicants, including those already determined eligible under another category of Medicaid assistance such as Louisiana Children's Health Insurance Program (LaCHIP). Additional eligibility criteria (resources, transfer of resources, trusts) are applicable for the CC waiver, which may not apply in some other categories of Medicaid.

The support coordination agencies (SCAs) will provide intake services, i.e. interview the family, and assist in gathering medical and other information necessary for eligibility determination. The SCA will then forward the completed application packet to the Medicaid eligibility office.

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

Simultaneously, the support coordinator will submit a packet to the appropriate LGE will make a home visit and issue a medical certification which is a BHSF form 142.

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

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

Level of Care

The CC Waiver is an alternative to institutional care. All waiver applicants must meet the definition of developmental disability as defined in Appendix A. The LGE will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD). If a SOD is issued, the application stops and the person is removed from the RFSR after all appeals have been exhausted. Individuals who receive a statement of approval continue to move forward in the process.

The OCDD "Request for Medical Eligibility Determination" 90-L form is the instrument used to determine if an applicant meets the LOC of an ICF/IID. The 90-L form is submitted by the Medicaid data contractor at the time the initial waiver offer is sent to the applicant/family. The 90-L form must be:

1. Completed 180 days or less before the date the CC Waiver service is approved to begin and annually thereafter;

2. Completed, signed and dated by the applicant's Louisiana licensed primary care physician (PCP). A licensed advanced nurse practitioner or licensed physician's assistant may sign the 90-L, but the supervising or collaborating physician's name and address must be listed; and

3. Submitted with the initial or annual POC.

The applicant/family is responsible for obtaining the completed 90-L form.

Choice of Service, Support Coordination and Direct Service Providers

Beneficiaries have freedom of choice (FOC) concerning whether or not to receive CC Waiver services and may select their SCA and direct service providers (DSPs).

Support Coordination

Support coordination is a service within the CC Waiver and is necessary for waiver participation. Beneficiaries may choose a SCA that is available and can accept new assignments in their region. For the first year, a beneficiary will remain with the same SCA. Thereafter, a beneficiary may request a change in SCAs every six months or for "good cause." (See Section 14.4 for "Procedures for Changing SCAs" for details on the process of changing support coordinators). Beneficiaries who cannot be reached by their support coordinators to arrange for evaluations, service planning, or review of services jeopardize their access to services.

Direct Service Providers

Beneficiaries have FOC of DSP agencies that are available in the region where they live. For the first year, a beneficiary will remain with the same agency. Thereafter, a beneficiary may change DSP agencies every 12 months or at any time for "good cause." (See Section 14.4 "Changing DSPs" for details on the process of changing service providers).

Admission Denial or Discharge Criteria

Admission into the waiver will be denied or beneficiaries will be discharged from the waiver for any of the following reasons:

1. Medicaid financial eligibility criteria is not met;

2. ICF/IID LOC criteria is not met as determined by the LGE;

3. Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities;

4. Beneficiary has a change of residence to another state or beneficiary lives in another state at the time of offer;

5. Admission to ICF/IID or nursing facility without the intent to return to waiver services. The waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The beneficiary will be discharged from

the waiver on the 91st day if still in the facility. Payment for waiver services will not be authorized when the beneficiary is in a facility;

6. The health, safety and welfare of the individual cannot be assured through the provision of reasonable amounts of waiver services in the community, i.e., presents a danger to themselves or others; and

7. Failure to cooperate in the eligibility determination process, the initial or annual implementation of the POC, or fulfilling their responsibilities as a CC waiver beneficiary.

In the event of a Force Majeure, SCAs, DSPs, and beneficiaries whenever possible, will be informed in writing, and/or by phone and/or via the Louisiana State Medicaid website of interim guidelines and timelines for retention of waiver slots and/or temporary suspension of continuity of services.

The DSP is required to notify the SCA within 24 hours if they have knowledge that the beneficiary has met any of the above stated discharge criteria.

RIGHTS AND RESPONSIBILITIES

Beneficiaries of the Louisiana Children's Choice (CC) Waiver services are entitled to the specific rights and responsibilities that accompany eligibility and participation in the Medicaid and CC Waiver programs.

Support coordinators and service providers must assist beneficiaries to exercise their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid to adhere to the following policies regarding beneficiary rights.

Freedom of Choice of Program

Applicants/beneficiaries who qualify for an Intermediate Care Facility for People with Intellectual Developmental Disabilities (ICF/IID) level of care (LOC) have the freedom to select institutional or community-based services. Applicants/beneficiaries have the responsibility to participate in the evaluation process. This includes providing the medical and other pertinent information or assisting in obtaining it for use in the person-centered planning process and certification for services.

Notification of Changes

The Louisiana Department of Health (LDH) - Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for Louisiana CC. In order to maintain eligibility, beneficiaries have the responsibility to inform BHSF of changes in their income, address, and living situation.

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

Participation in Care

Support coordinators and service providers shall allow beneficiaries/authorized representatives to participate in all person-centered planning meetings and any other meeting concerning their services and supports. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary's needs. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services.

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

At the request of the beneficiary/authorized representative, the support coordinator must request changes in the amount of services at least seven days before taking effect, except in emergencies. Service providers may not initiate requests for change of service or modify the POC without the participation and consent of the beneficiary.

Freedom of Choice of Support Coordination and Service Providers

The beneficiary/authorized representative has a choice of support coordination agencies (SCAs) and service providers whenever there is a choice available.

Beneficiaries/authorized representative may request a change in SCAs at the time of admission to the waiver and every six months thereafter or with good cause by contacting the Human Service Authority or District.

Support coordinators will provide beneficiaries/authorized representative with their choice of direct service providers (DSPs) and help arrange for the service included in the POC.

Voluntary Participation

Providers must assure that the beneficiary's health and welfare needs are met. As part of the planning process, methods to comply with these assurances may be negotiated to suit the beneficiary's needs and outcomes. Beneficiaries have the right to refuse services, to be informed of the alternative services available to them, and to know the consequences of their decisions. Therefore, a beneficiary will not be required to receive services that they may be eligible for but does not wish to receive. The intent of Louisiana CC Waiver is to provide home and community-based services (HCBS) to individuals who would otherwise require institutionalization.

Compliance with Civil Rights

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

Quality of Care

Providers must be competent, trained, and qualified to provide services to beneficiaries as outlined in the POC. In cases where services are not delivered according to the POC, or there is abuse or neglect on the part of the provider, the beneficiary shall follow the complaint reporting procedure and cooperate in the investigation and resolution of the complaint. Beneficiaries may not request providers to perform tasks that are illegal or inappropriate and may not violate the rights of providers.

Grievances/Fair Hearings

Each support coordination/DSP shall have grievance procedures through which beneficiaries may grieve the supports or services they receive. The support coordinator shall advise beneficiaries of this right and of their rights to appeal any denial or exclusion from the program or failure to recognize a beneficiary's choice of a service and of their right to a fair hearing through the Medicaid program. In the event of a fair hearing, a representative of the service provider and SCA shall appear and participate in the proceedings.

The beneficiary has a responsibility to bring problems to the attention of providers or the Medicaid program and to participate in the grievance or appeal process.

Rights and Responsibilities of Families

The support coordinator must review these rights and responsibilities with the beneficiary/family as part of the initial intake process into waiver services. (See Appendix D for information on where to obtain a complete list of the beneficiary's rights and responsibilities).

SERVICE ACCESS AND AUTHORIZATION

Office of Citizens with Developmental Disabilities (OCDD) waivers has been operationalized to a tiered waiver system of service delivery, which will allow individuals to be supported in the most appropriate waiver. Home and community-based opportunities will now be provided based on the individual's prioritized need for support, which was identified in their Request for Services Registry (RFSR) Screening for Urgency of Need (SUN). Instead of first come, first served, individuals with the most emergent and urgent need for support will have priority. When funding is appropriated for a new Children's Choice (CC) Waiver opportunity, or an existing opportunity is vacated, the next individual on the RFSR with the highest urgency of need screening score will receive a written notice indicating that a waiver opportunity is available. That individual will receive a needs based assessment and participate in the person-centered planning process. At the conclusion of that process, it will be determined which waiver is the most appropriate for the individual in the tiered waiver process. A CC Waiver slot will be extended if the individual is between the ages of 0-20 and if this is the most appropriate waiver. An offer will not be extended if the individual is seeking employment and/or day habilitation services.

The applicant will receive a waiver offer packet that includes a Support Coordination Agency (SCA) Freedom of Choice (FOC) form. The support coordinator is a resource to assist individuals in the coordination of needed supports and services. The applicant must complete and return the packet to be linked to a SCA.

Once linked, the support coordinator will assist the applicant in gathering the documents which may be needed for both the financial eligibility and medical certification process for level of care (LOC) determination. The support coordinator informs the individual of the FOC of enrolled waiver providers, the availability of services as well as the assistance provided through the support coordination service.

Once it has been determined that the applicant meets the LOC requirements for the program, a second home visit is made to finalize the plan of care (POC). The following must be addressed in the POC:

1. The applicant's assessed needs;

2. The types and number of services (including waiver and all other services) necessary to maintain the applicant safely in the community;

3. The individual cost of each waiver service (including waiver and all other services); and

4. The total cost of services covered by the POC.

Provider Selection

The support coordinator must present the beneficiary with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the POC. The support coordinator will have the beneficiary or responsible representative complete the provider FOC form initially and annually thereafter for each identified waiver service.

The support coordinator is responsible for:

1. Notifying the provider that the beneficiary has selected their agency to provide the necessary service;

2. Scheduling a meeting with the provider and the beneficiary to discuss services needed by the;

3. Requesting the provider sign and return the:

    a. Provider Agreement form and budget pages;

    b. Emergency plan; and

    c. Individualized staffing back-up plan.

4. Forwarding the POC packet to the local Human Services Authority or District for review and approval.

NOTE: The authorization to provide service is contingent upon approval by the Human Services Authority or District.

Prior Authorization

Prior authorization (PA) is the process to approve specific services prior to service delivery and reimbursement for an enrolled Medicaid beneficiary by an enrolled Medicaid provider. The purpose of PA is to validate the service that is requested is medically necessary and meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon passing all the edits contained within the claims payment process, the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service. PAs are issued in quarterly intervals directly to the provider, with the last quarterly authorization ending on the POC end date.

PA revolves around the POC document and any subsequent revision, which means that only the service codes and units specified in the approved POC will be considered for PA. Services provided without PA are not eligible for reimbursement.

The service provider is responsible for the following activities:

1. Checking PAs to ensure all PAs for services match the approved services in the beneficiary's POC. Any mistakes must be immediately corrected to match the approved services in the POC;

2. Verifying the direct service worker's (DSW's) timesheet or electronic clock in/out is completed correctly and services were delivered according to the beneficiary's approved POC before billing for the service;

3. Verifying that services were documented as evidenced by timesheets and progress notes and are within the approved service limits as identified in the beneficiary's POC;

4. Verifying service data in the direct service provider (DSP), Electronic Visit Verification (EVV) system or LaSRS depending on the service and modifying the data, if needed, based on actual service delivery;

5. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;

6. Billing only for the services that were approved in the beneficiary's POC and delivered to the beneficiary;

7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary (FI) with each payment; and

8. Checking billing records to ensure the appropriate payment was received.

NOTE: Service providers have one-year timely filing billing requirement under Medicaid regulations.

In the event that reimbursement is received without a PA, the amount paid is subject to recoupment.

NOTE: Authorization for services will not be issued retroactively unless approved due to special circumstances by the OCDD Waiver Director/ Designee.

Post Authorization

To receive post authorization, a service provider must ensure that the service delivery information is reported accurately in the post authorization system maintained by the Medicaid data contractor. The Medicaid data contractor checks the information entered into the billing system by the service provider against the prior authorized unit(s) of service. Once post authorization is granted, and the billing is correctly submitted by the service provider, reimbursement for the appropriate units of service will occur.

Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

Changing Direct Service Providers

Beneficiaries/authorized representatives may change DSPs once every 12 months. All requests for changes in services and/or service hours must be made by the beneficiary/authorized representatives.

DSPs may be changed for good cause at any time as approved by the local governing entity (LGE).

Good cause is defined as:

1. A beneficiary/family moving to another region in the state where the current DSP does not or cannot provide services;

2. The beneficiary/family and the DSP have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health, safety or welfare have been compromised; or

4. The DSP has not rendered services in a manner satisfactory to the beneficiary/family.

The beneficiaries/authorized representatives must contact their support coordinator to change DSPs.

The support coordinator will assist in facilitating a team meeting involving the current DSP(s) if agreed to by the beneficiary/authorized representatives. This meeting will address the reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider will have the opportunity to submit a corrective action plan with specific time lines, not to exceed 30 days to attempt to meet the needs of the beneficiary.

If the beneficiary/authorized representative refuses a team meeting, the support coordinator and the LGE determines that a meeting is not possible or appropriate, or the corrective action plan and timelines are not met, the support coordinator will:

1. Provide the beneficiary/authorized representative with the current FOC list of service providers in their region;

2. Assist the beneficiary/representative in completing the FOC and release of information form;

3. Ensure the current provider is notified immediately upon knowledge of the request and prior to the transfer; and

4. Obtain the case record from the releasing provider which must include:

    a. Progress notes from the last two months, or if the beneficiary has received services from the provider for less than two months, all progress notes from date of admission;

    b. Written documentation of services provided, including monthly and quarterly progress summaries;

    c. Current POC;

    d. Records tracking beneficiary's progress towards POC goals and objectives;

    e. Behavior management plans, current and past if applicable;

    f. Documentation of the amount of authorized services remaining in the POC; including applicable time sheets; and

    g. Documentation of exit interview.

The support coordinator will forward copies of the following to the new service provider:

1. Most current POC;

2. Current assessments on which POC is based;

3. Number of services used in the calendar year;

4. Records from the previous service provider; and

5. All other waiver documents necessary for the new service provider to begin providing supports and services.

NOTE: Transfers must be made at least seven calendar days prior to the end of the service authorization quarter. The start date should be effective the first day of the new quarter in order to coordinate services and billing. The Human Services District or Authority may waive this requirement in writing due to good cause, at which time the start date will be the first day of the first full calendar month.

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

Prior Authorization for New Service Providers

The support coordinator will complete the POC revision form with the start date for the new provider and the end date for the transferring provider and submit the revision request to the Human Services Authority or District for approval. Upon approval, a new PA number will be issued to the new provider with the effective starting date. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider.

Neither the Human Services Authority or District nor its agent will 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 beneficiary in the middle of a month, the new provider cannot bill for services until the first day of the next month. New providers who provide services prior to the begin date of the new PA period will not be reimbursed.

Exceptions to the existing service provider end date and the new service provider begin date may be approved by the Human Services Authority or District when the reason for the change is due to good cause.

Changing Support Coordination Agencies

A beneficiary may change support coordination agencies after a six month period or at any time for good cause if the new agency has not met their maximum number of beneficiaries. Good cause is defined as:

1. A beneficiary/authorized representatives' family moving to another region in the state;

2. The beneficiary/family and the SCA have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health, safety or welfare have been compromised; or

4. The SCA has not rendered services in a manner satisfactory to the beneficiary/family.

Participating support coordination agencies should refer to the Case Management Services manual chapter in the *Louisiana Medicaid Provider Manual* which provides a detailed description of their roles and responsibilities.

Changes in Authorized Services

Any change or revision to the POC must be prior approved by the Human Services Authority or District. Requests for changes to the POC must be made by the beneficiary/authorized representative to the support coordinator. Changes will not be made solely on the request of the service provider.

The beneficiary/authorized representative may not authorize services or authorize DSWs to work hours or services not included in the approved POC.

PROVIDER REQUIREMENTS

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid program, a provider must:

1. Meet all of the requirements for licensure as established by state laws and rules promulgated by the Louisiana Department of Health (LDH);

2. Agree to abide by all rules and regulations established by the Centers for Medicare and Medicaid Services (CMS), LDH and other state agencies if applicable; and

3. Comply with all the terms and conditions for Medicaid enrollment.

Providers must attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) and/or the Human Services Authorities or Districts as a condition of enrollment and continued participation as a waiver provider. Attendance at a provider enrollment orientation is required prior to enrollment as a Medicaid provider. A Provider Enrollment Packet must be completed for each LDH administrative region in which the agency will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number.

Providers must participate in the initial training for prior authorization (PA) and data collection and any training provided on changes in the system. Initial training is provided at no cost to the agency. Any repeat training must be paid for by the requesting agency.

Providers must have the necessary computer equipment and software available to participate in PA and data collection.

All providers must maintain a toll-free telephone line with 24-hour accessibility manned by an answering service. This toll-free number must be given to beneficiaries/guardians at intake or at the first meeting.

Brochures providing information on the agency's experience must include the agency's toll-free number along with the OCDD's toll-free information number. All brochures are subject to OCDD approval prior to distribution.

Providers must develop a Quality Improvement and Self-Assessment Plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first Self-Assessment is due six months after approval of the Quality Improvement Plan (QIP) and yearly thereafter. The QIP must be submitted for approval within 60 days after the training is provided by LDH.

Providers must be certified for a period of one year. Re-certification must be completed no less than 60 days prior to the expiration of the certification period.

The agency must not have been terminated or actively sanctioned by Medicaid, Medicare or other health-related programs in Louisiana or any other state. The agency must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state. The agency shall document that its employees and the employees of subcontractors do not have a criminal record as defined in 42 Code of Federal Regulations (CFR) 441.404(b).

Changes in the following areas are to be reported to the Office of the Secretary's Health Standards Section (HSS), OCDD and the fiscal intermediary's (FI's) Provider Enrollment Section in writing at least 10 days prior to any change:

1. Ownership;

2. Physical location;

3. Mailing address;

4. Telephone number; and

5. Account information affecting electronic funds transfer (EFT).

The provider must complete a new provider enrollment packet when a change in ownership of five percent to 50 percent of the controlling interest occurs, but may continue serving beneficiaries. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving beneficiaries until the re-certification process is complete.

Waiver services are to be provided only to persons who are waiver beneficiaries, and strictly in accordance with the provisions of the approved plan of care (POC).

Providers may not refuse to serve any waiver beneficiary that 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. Such refusal to serve an individual must be put in writing by the provider, and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the local Human Service Authority or District. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver beneficiary referred to them by the enrolled direct service provider (DSP) agency.

The beneficiary's provider and support coordination agency (SCA) must have a written working agreement that includes the following:

1. Written notification of the time frames for POC planning meetings;

2. Timely notification of meeting dates and times to allow for provider participation;

3. Information on how the agency is notified when there is a POC or service delivery change; and

4. Assurance that the appropriate provider representative is present at planning meetings as invited by the beneficiary.

Support Coordination Provider Requirements

Providers of support coordination for the Children's Choice (CC) Waiver program must:

1. Have a current, valid support coordination license;

2. Meet all requirements for targeted case management services as set forth in Louisiana Administrative Code (LAC) 50:XV Chapter 105;

3. Have a signed performance agreement with OCDD to provide services to waiver beneficiaries. Support coordination agencies (SCAs) must meet all of the performance agreement requirements; and

4. Meet any additional criteria outlined in the Medicaid Case Management Services manual chapter.

Direct Service Provider Requirements

DSPs must be licensed by the LDH as a home and community-based services (HCBS) provider and meet the module specific requirements for the services being provided. DSPs must provide at a minimum the Family Support and Crisis Support services. Other direct services outlined below may be provided directly by the DSP or by a written agreement (subcontract) with other agents. The actual provider of the service, whether it is the DSP or a subcontracted agent, must meet the following licensure or other qualifications:

Waiver Service	Licensure Requirements	Service Provided by
Family Support	HCBS Provider Minimum Licensing Standards – Personal Care Attendant	Enrolled agency
Crisis Support		
Center-Based Respite	HCBS Provider Minimum Licensing Standards – Respite Care – Center-Based Respite Care	Enrolled/licensed agency or through an agreement and reimbursed through the enrolled agency

Waiver Service	Licensure Requirements	Service Provided by
Family Training	No license required	Professionals at approved meetings and reimbursed through the enrolled agency
Ramp – Home	Registered through the Louisiana State Licensing Board for Contractors as a Home Improvement Contractor.	An individual/agency deemed capable to perform the service by the beneficiary's family and DSP agency. Payment reimbursed through the enrolled provider
Bathroom Modifications		
General Adaptations		
Vehicle Lifts	Licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.	
Specialized Medical Equipment and Supplies	Meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.	Medicaid enrolled durable medical equipment provider
Therapy Services: Aquatic Therapy, Art Therapy, Music Therapy, Hippotherapy/Therapeutic Horseback Riding, and Sensory Integration	Enrolled as Individual Waiver Therapy Provider with applicable sub-specialty	Individual Waiver Therapist

Waiver Service	Licensure Requirements	Service Provided by
Housing Stabilization Transition Services	Provider agency who is under contract and enrolled with LDH's Statewide Management Organization for Behavioral Services who meet requirements for completion of training program verified by the Permanent Supportive Housing director with at least one year experience	Individual Permanent Supportive Housing Program Agency
Housing Stabilization Services		

When required by state law, the person performing the service, such as building contractors, plumbers, electricians, or engineers, must meet applicable requirements for professional licensure and modifications to the home and must meet all applicable building code standards.

It is the responsibility of the enrolled family support provider to verify the provider's qualifications, reimburse other providers for their services and maintain records of service delivery in the agency's office located in the appropriate LDH administrative region.

Professional Services Provider Requirements

Individual practitioners of therapy services (aquatic, art, music, hippotherapy/horseback riding, and sensory integration) must enroll as a Medicaid provider and meet the following criteria:

1. Have a current, valid license or certification from the appropriate governing board for that profession; and

2. Possess one year of post-licensure or certification experience consistent with the scope of the license or certification held by the professional.

Provider Responsibilities

Support Coordination Providers

Support coordination providers are responsible for the following:

1. Facilitating the development of the POC with the beneficiary/family, authorized representative and DSP;

2. Reviewing the POC at least quarterly to:

    a. Determine that the goals and objectives in the POC have been achieved;

b. Determine that the beneficiary's needs are being met;

c. Assess satisfaction with scheduled services; and

d. Make adjustments or changes to the POC; if necessary.

3. Revising the POC when requests are made from the beneficiary/family; and

4. Scheduling and facilitating the annual POC meeting.

NOTE: Refer to Section 14.11 – Support Coordination for additional information regarding support coordination responsibilities.

Direct Service Providers

The DSP is responsible for the following:

1. Ensuring an appropriate representative from the agency attends the POC planning meeting and is an active participant in the team meeting;

   NOTE: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the beneficiary's service delivery. This person may be a program manager, a direct service professional who works with or will work with the beneficiary, the executive director or designee.

2. Communicating and working with support coordinators and other support team members to achieve the beneficiary's personal outcomes;

3. Ensuring the beneficiary's emergency contact information and list of medications are kept current;

4. Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or time lines in the POC will not meet the beneficiary's needs, but not later than 10 days prior to the expiration of any time lines in the POC that cannot be met;

5. Ensuring all support team members sign and date any revisions to the POC indicating agreement with the changes to the goals, objectives or time lines;

6. Providing the SCA or LDH representatives with requested written documentation including, but not limited to:

a. Completed, signed and dated POC;

b. Service logs, progress notes, and progress summaries;

c. Direct service worker (DSW) attendance and payroll records;

d. Written grievances or complaints filed by beneficiaries/family;

e. Critical or other incident reports involving the beneficiary; and

f. Entrance and exit interview documentation.

7. Ensuring all staff receives training within established time lines as specified in licenses, certifications, etc.;

8. Explaining to the beneficiary/family in their native language the beneficiary rights and responsibilities within the agency; and

9. Assuring that beneficiaries are free to make a choice of providers without undue influence.

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

1. Training policy that includes orientation and staff training requirements according to the HCBS Provider Minimum Licensing Standards for Personal Care Attendant and the DSW Registry rule;

2. Direct care abilities, skills and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver beneficiaries;

3. Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing and staff coverage plan;

4. Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal;

5. Identification, notification and protection of beneficiary's rights both verbally and in writing in a language the beneficiary/family is able to understand;

6. Written grievance procedures; and

7. Information about abuse and neglect as defined by LDH regulations and state and federal laws.

Back-up Planning

DSPs are responsible for providing all necessary staff to fulfill the health and welfare needs of the beneficiary when paid supports are scheduled to be provided. This includes times when the scheduled DSW is absent or unavailable or unable to work for any reason.

All DSPs are required to develop a functional individualized back-up plan for each beneficiary that includes detailed strategies and person-specific information that addresses the specialized care and supports needed by the beneficiary. DSPs are required to have policies in place which outline the protocols the agency has established to assure that back-up DSWs are readily available, lines of communication and chain of command procedures have been established, and procedures for dissemination of the back-up plan information to beneficiaries, their authorized representatives and support coordinators. Protocols must also describe how and when the direct support staff will be trained in the care needed by the beneficiary. This training must occur prior to any direct support staff being solely responsible for a beneficiary.

Back-up plans must be updated at least annually to assure that the information is kept current and applicable to the beneficiary's needs. The back-up plan must be submitted to the beneficiary's support coordinator in a timely manner to be included as a component of the beneficiary's initial and annual POC.

Emergency Evacuation Planning

The emergency evacuation plan must be included in the beneficiary's POC and provide detailed information which specifies how the DSP will respond to potential emergency situations, such as fires, hurricanes, hazardous material release, tropical storms, flash flooding, ice storms, and terrorist attack.

The emergency evacuation plan must be person-specific and include the following components:

1. Individualized risk assessment of potential health emergencies;

2. A detailed plan that addresses the beneficiary's evacuation needs, including a review of the beneficiary's back-up plan during geographical and natural disaster emergencies and all other potential emergency conditions;

3. Policies and procedures outlining the agency's implementation of emergency evacuation plans and the coordination of these plans with the local Office for Emergency Preparedness and Homeland Security;

4. Establishment of effective lines of communication and chain-of-command procedures;

5. Establishment of procedures for the dissemination of the emergency evacuation plan to beneficiaries and support coordinators; and

6. Protocols outlining how and when DSWs and beneficiaries will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

The beneficiary must be provided with regular, planned opportunities to practice their emergency evacuation response plan.

Support coordination and DSP agencies are responsible for following the *"*Emergency Protocol for Tracking Location Before, During, and After Hurricanes." (See Appendix D for information on obtaining a copy of this document).

STAFFING REQUIREMENTS

The Louisiana Department of Health (LDH) has the responsibility to establish reasonable qualifications for providers to ensure that they are capable of providing services of acceptable quality to beneficiaries. The provider qualifications delineated in this section are dictated by the needs of the population to be served, and by the duties and responsibilities inherent in the provision of services as defined by LDH. LDH has established these staffing requirements to maintain an adequate level of quality, efficiency, and professionalism in the provision of all services in the Children's Choice (CC) Waiver program.

All personnel who are at a supervisory level must have a minimum of one-year verifiable work experience in planning and providing direct services to people with intellectual disabilities or other developmental disabilities.

Providers must:

1. Document that criminal record history checks have been obtained;

2. Ensure that employees and the employees of subcontractors do not have a criminal record as defined in 42 Code of Federal Regulations (CFR) 441.404 (b) which states that providers of community supported living arrangements services do not employ individuals who have been convicted of child abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual; and

3. Take all reasonable steps to determine whether applications for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

Failure to comply with these regulations may result in any or all of the following:

1. Recoupment;

2. Sanctions;

3. Loss of enrollment; or

4. Loss of licensure.

Support Coordination Requirements

The criteria for staffing and credentialing in addition to training and supervision are found in the Case Management Services manual chapter. Support coordination providers should refer to this document to assure compliance with waiver requirements.

Direct Service Provider Requirements

Direct service providers (DSPs) must ensure that all direct service staff possess the minimum requisite skills, qualifications, training, supervision, and coverage in accordance with the Home and Community-Based Services (HCBS) Licensing Standards (Personal Care Attendant module), the HCBS Waiver Program Standards of Participation, and the Direct Service Worker (DSW) Registry. Providers must maintain sufficient staff and office site(s) to adequately serve beneficiaries in the LDH region(s) where they are enrolled.

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

1. Legally responsible relatives (spouses, parents or stepparents, foster parents, or legal guardians); or

2. Any other relative who lives in the same household with the beneficiary.

Family members who provide family support services must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant. Service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by staff living in the home.

Legally responsible individuals (such as a parent or spouse) and legal guardians may provide family support services for their own child, provided that the care is extraordinary in comparison to that of a child of the same age without a disability and the care is in the best interest of the child.

Legally responsible individuals and legal guardians may not provide family support services delivered through self-direction.

RECORD KEEPING

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the enrolled office site in the Louisiana Department of Health (LDH) administrative region where the beneficiary resides. The agency must have sufficient space, facilities, and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the beneficiary served and the provision of services.

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

Confidentiality and Protection of Records

Records, including administrative and beneficiary, must be secured against loss, tampering, destruction, or unauthorized use. Providers must comply with the confidentiality standards as set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and in Louisiana law.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the beneficiaries or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiaries or their families. The wrongful disclosure of such information may result in the imposition by the LDH or 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 the HIPAA Privacy Rule. The information may be released only under the following conditions:

1. Court order;

2. Beneficiary's written informed consent for release of information;

3. Written consent of the individual to whom the beneficiary's rights have been devolved when the beneficiary has been declared legally incompetent; or

4. Written consent of the parent or legal guardian when the beneficiary is a minor.

A provider must, upon request, make available information in the case records to the beneficiary

or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the beneficiary, or reasonably likely to endanger the life or physical safety of the beneficiary, that information may be withheld. This determination must be documented in writing.

The provider may charge a reasonable fee for providing the above records. The cost of copying cannot exceed the community's competitive copying rate.

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

A system must be maintained that provides for the control and location of all beneficiary records. Beneficiary records must be located at the enrolled site. **Under no circumstances should providers allow staff to take beneficiary's case records from the facility.**

Review by State and Federal Agencies

Providers must make all administrative, personnel, and beneficiary records available to LDH and appropriate state and federal personnel at all reasonable times.

Retention of Records

The agency must retain administrative, personnel, and beneficiary records for whichever of the following time frames is longer:

1. Until records are audited and all audit questions have been answered to the satisfaction of all parties involved;

OR

2. Six years from the date of the last payment period.

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

Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, the LDH Home and Community-Based Services (HCBS) Wavier Standards for Participation rule and Medicaid enrollment agreements.

Beneficiary Records

A provider must have a separate written record for each beneficiary served by the agency. It is the responsibility of the provider to have adequate documentation of services offered to waiver beneficiaries for the purposes of continuity of care, support for the individuals and the need for adequate monitoring of progress toward outcomes and services received. This documentation is an on-going chronology of services received and undertaken on behalf of the beneficiary.

Beneficiary 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.

The Office of Citizens with Developmental Disabilities (OCDD) does not prescribe a specific format for documentation, but must find all components outlined below in each beneficiary's active record.

Organization of Records, Record Entries and Corrections

The organization of individual beneficiary records and the location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.

All entries and forms completed by staff in beneficiary records must be legible, written in ink and include the following:

1. Name of the person making the entry;
2. Signature of the person making the entry;
3. Functional title of the person making the entry;
4. Full date of documentation; and
5. Supervisor review, if required.

Any error made by the staff in a beneficiary's record must be corrected using the legal method by drawing a line through the incorrect information, writing "error" next to the correction, and initialing the correction. Correction fluid must never be used in a beneficiary's records.

Components of Beneficiary Records

The beneficiary's case record must consist of the active beneficiary record and the agency's storage files or folders. The active record must contain, *at a minimum*, the following information:

1. Identifying information on the beneficiary that is recorded on a standardized form to include the following:

    a. Name;

    b. Home address;

    c. Home telephone number;

    d. Date of birth (DOB);

    e. Sex;

    f. List of current medications;

    g. Primary and secondary disability;

    h. Name and phone number of preferred hospital;

    i. Closest living relative;

    j. Marital status;

    k. Name and address of current employment, school, or day program, as appropriate;

    l. Date of initial contact;

    m. Court and/or legal status, including relevant legal documents, if applicable;

    n. Names, addresses, and phone numbers of other beneficiaries or providers involved with the beneficiary's plan of care (POC) including the beneficiary's primary or attending physician;

o. Date this information was gathered; and

p. Signature of the staff member gathering the information.

2. Documentation of the need for ongoing services;

3. Medicaid eligibility information;

4. A copy of assurances of freedom of choice of providers, beneficiary rights and responsibilities, confidentiality, and grievance procedures, etc. signed by the beneficiary;

5. Approved POC, and provider documents, including any revisions;

6. Complete Individualized Service Plan (ISP);

7. Copy of all critical incident reports, if applicable;

8. Formal grievances filed by the beneficiary;

9. Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified in the Service Documentation section;

10. Attendance records;

11. Copy of the beneficiary's behavior support plan, if applicable;

12. Documentation of all interventions (medical, consultative, environmental and adaptive) used to ensure the beneficiary's health, safety, and welfare;

13. Reason for case closure and any agreements with the beneficiary at closure;

14. Copies of all pertinent correspondence;

15. At least six months (or all information if services provided less than six months) of current pertinent information relating to services provided;

NOTE: Records older than six months may be kept in storage files or folders, but must be available for review.

16. Any threatening medical condition including a description of any current treatment

or medication necessary for the treatment of any serious or life threatening medical condition or any known allergies;

17. Monitoring reports of waiver service providers to ensure that the services outlined in the POC are delivered as specified;

18. Service logs describing all contacts, services delivered and/or action taken identifying the beneficiaries involved in service delivery, the date and place of service, the content of service delivery and the services relative to the POC;

19. A sign-out sheet that indicates the date and signature of the person(s) who viewed the record; and

20. Any other pertinent documents.

If the provider transports the beneficiary at any time, a separate record for each beneficiary transported must be in the vehicle whenever the beneficiary is being transported. At a minimum, this individual record should contain the following beneficiary information:

1. Name;

2. Telephone number;

3. Address;

4. Emergency contacts;

5. Medicaid and/or Medicare insurance number and any other insurance card number;

6. Current medications;

7. Physician's name, telephone number and address;

8. Preferred hospital;

9. Current medical conditions including allergies; and

10. Preferred religion (if stated).

After transportation has been provided, the beneficiary's transportation records must be returned to a secure, locked location in the provider agency. Beneficiary's transportation records must not be left in a vehicle.

Service Documentation

Support coordination agencies (SCAs) and direct service providers (DSPs) are responsible for documenting activities during the delivery of services. All documentation content and schedule requirements must be met by both SCAs and DSPs.

Required service documentation includes:

1. Service logs;
2. Progress notes;
3. Progress summaries;
4. Discharge summaries for transfers and closures; and
5. Individualized documentation.

NOTE: DSPs, who provide both waiver and state plan services, must maintain separate documentation for these services.

Service Logs

A service log provides a chronological listing of contacts and services provided to a beneficiary. It reflects the service(s) delivered and documents the service(s) billed.

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

1. Name of beneficiary;
2. Name of provider and employee providing the service;
3. Service agency contact telephone number;
4. Date of service contact;
5. Start and stop time of service contact;

NOTE: The electronic visit verification (EVV) system will be used to document the start/stop time of service contact. If there is no electronic clock in/out, then the paper documentation identifying the exact start and stop times with the date of the service contact is required, including

the worker's signature.

6. Purpose of service contact

    a. Personal outcomes addressed; and

    b. Other issues addressed;

7. Content and outcome of service contact; and

8. Place of service contact.

There must be case record entries corresponding to each recorded SCA and DSP activity which relates to one of the personal outcomes.

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

Services billed must clearly be related to the current POC.

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

DSPs must complete a narrative which reflects each entry into the payroll sheet and elaborates on the activity of the contact.

Progress Notes

Progress notes must be completed by both support coordinators and DSPs at the time of each activity or service. Progress notes summarize the beneficiary's day-to-day activities and progress toward achieving their personal outcomes as identified in the approved POC. Progress notes must be of sufficient content to:

1. Reflect descriptions of activities, procedures, and incidents;

2. Give a picture of the service provided to the beneficiary;

3. Show progress towards the beneficiary's personal outcomes;

4. Record any change in the beneficiary's medical condition, behavior, or home situation which may indicate a need for reassessment and POC change;

5. Record any changes or deviations from the typical weekly schedule in the beneficiary's approved POC; and

6. Reflect each entry in the service log and/or timesheet.

Checklists alone are not adequate documentation for progress notes.

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

1. "Supported _____";

2. "Assisted _____";

3. "_____ is doing fine";

4. "_____ had a good day"; and

5. "Prepared meals".

Progress notes must be reviewed by the supervisor to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

Progress Summary

A progress summary is a synthesis of all activities for a specified period which address significant activities, progress toward the beneficiary's desired personal outcomes, and changes in the beneficiary's social history. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the beneficiary's current POC, sufficient information for use by other support coordinators, direct service workers (DSWs), or their supervisors, and evaluation of activities by program monitors.

Support coordinators and DSPs may include the progress summary in the service log for this documentation requirement.

A progress summary must be completed at least every quarter for each beneficiary.

Discharge Summary for Transfers and Closures

A discharge summary is a synopsis of the beneficiary's progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a beneficiary's discharge.

Support coordinators and DSPs may include the discharge summary in the service log for this documentation requirement.

Individualized Documentation

The support team must ensure that other documentation and data collection methods other than progress notes, progress summaries, and discharge summaries are considered so that appropriate measures are used to track the beneficiary's progress toward their goals and objectives as specified in the approved POC.

For persons with behavioral, psychiatric, or medical risk factors, individualized documentation must be utilized as a means of tracking each key area of risk. This documentation is required, but not limited to, beneficiaries with the following risk factors:

1. Seizure disorder and/or receiving seizure medication – Data forms used to track this information must include seizure reports. The support team may also need to consider assessing for the presence of side-effects of seizure medication on a monthly or quarterly basis;

2. A medical issue which is significantly affected by or has a significant effect upon one's weight – Such issues may include diabetes, cardiovascular issues, medication side-effects, or receiving nutrition via g-tube, peg-tube, etc. Data forms used to track this information must include weight logs. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, and assessing for the presence of medication side-effects;

3. Medications which can have severe side effects or potentially cause death if the adherence to medication management protocols is not strictly followed. Data forms used to track this information must include an assessment for the presence of medication side-effects on a monthly or quarterly basis. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, and tracking frequency/consistency of bowel movements with a daily bowel log;

4. A psychiatric diagnosis and/or receiving psychotropic medication. Data forms used to track this information must include a psychiatric symptoms assessment. Based

on the beneficiary's presenting symptoms, antecedents, and psychotropic medication guidelines, the support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, tracking frequency/intensity of challenging behaviors with a challenging behavior chart, and assessing for the presence of medication side-effects; and

5. Challenging behaviors which are severe or disruptive enough to warrant a behavioral treatment plan. Data forms used to track this information must include behavioral incident reports. The support team may also need to consider tracking frequency/intensity of psychiatric symptoms with a psychiatric symptoms assessment, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, and assessing for the presence of medication side-effects.

The Individual and Family Support (IFS) provider is responsible for collecting all required individualized documentation for the risk factors listed above and making it available to professionals, nursing, and medical personnel providing services to the beneficiary in order to facilitate quality of care. The data collection mechanism (e.g. the form or other collection method) related to these items must be submitted with the beneficiary's POC and, if altered, with any succeeding revisions.

Schedule of Required Documentation

SUPPORT COORDINATION AGENCIES AND DIRECT SERVICE PROVIDERS			
SERVICE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/TRANSFER
At time of activity	At time of activity	Between 6th and 9th month OR More frequently if indicated.	Within 14 days of discharge

REIMBURSEMENT

All claims for Children's Choice (CC) Waiver services shall be a prospective flat rate for each approved unit of service provided to the beneficiary. Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. Refer to Appendix E for information about the procedure code, unit of service and current reimbursement rate.

Up to two participants may choose to share family support services if they share a common provider of this service. Family support services may share a direct support worker (DSW) across two waivers: the Residential Options Waiver (ROW) (community living supports) and/or New Opportunities Waiver (NOW) (individual and family supports). However, sharing a DSW at the same time across all three waivers is not allowed.

The claim submission date cannot precede the date the service was rendered.

All claims for CC Waiver services shall be filed by electronic claims submissions 837P or on the CMS-1500 claim form.

Direct Support Worker Wages

Effective for dates of service on or after October 1, 2021, providers of Medicaid home and community-based services (HCBS) waiver services operated through the Office for Citizens with Developmental Disabilities (OCDD) employing defined DSWs will receive the equivalent of a $2.50 per hour rate increase. This increase or its equivalent will be applied to all service units provided by DSWs with an effective date of service for the identified HCBS waiver provided beginning October 1, 2021.

All providers of services affected by this rate increase shall be subject to a DSW minimum hourly wage floor of $9.00 per hour. This wage floor is effective for all affected direct support workers of any work status (full-time, part-time, etc.)

The Louisiana Department of Health (LDH) reserves the right to adjust the DSW wage floor as needed through appropriate rulemaking promulgation consistent with the Louisiana Administrative Procedure Act.

Audit Procedures

The wage enhancement payments reimbursed to providers shall be subject to audit by LDH. Providers shall provide to LDH or its representative all requested documentation to verify compliance with the DSW wage floor upon request and within the time frame provided by the

LDH.

Documentation may include, but is not limited to:

1. Payroll records;
2. Wage and salary sheets; and
3. Check stubs, etc.

Non-compliance or failure to demonstrate that the wage enhancement was paid directly to DSWs may result in:

1. Sanctions; or
2. Disenrollment in the Medicaid program.

Sanctions

The provider will be subject to sanctions or penalties for failure to comply with requests issued by LDH. The severity of such action will depend on:

1. Failure to pay I/ID HCBS DSWs the floor minimum of $9.00 per hour;
2. Number of employees identified as having been paid less than the $9.00 per hour floor;
3. Persistent failure to pay the floor minimum of $9.00 per hour; or
4. Failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance.

New Opportunities Waiver Fund

LDH shall deposit civil fines and the interest collected from providers into the NOW Fund.

PROGRAM MONITORING

Services offered through Louisiana Children's Choice (CC) Waiver are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal regulations. The Louisiana Department of Health's (LDH's) Health Standards Section (HSS) staff conducts on-site reviews of each provider agency as needed for compliance with licensing regulations.

A provider's failure to follow State licensing standards and Medicaid policies and practices could result in the provider's loss of licensure, removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

Fraud and Abuse

When HSS staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section of the Medicaid Program for investigation and sanctions, if necessary. Investigations and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) of the Medicaid Program. LDH has an agreement with the Office of the Attorney General to investigate Medicaid fraud. The Office of the Inspector General (OIG), Federal Bureau of Investigation (FBI), and postal inspectors also conduct investigations of Medicaid fraud.

Quality Management

Direct service providers (DSPs) and support coordination agencies (SCAs) must have a quality enhancement process that involves:

1. Learning;
2. Responding;
3. Implementing; and
4. Evaluating.

Agency quality enhancement activities must be reviewed and approved by the regional Office for Citizens with Developmental Disabilities (OCDD) as described in the *Quality Enhancement Provider Handbook*. (See Appendix D for information regarding this handbook).

INCIDENTS, ACCIDENTS, AND COMPLAINTS

The support coordination agency (SCA) and direct service provider (DSP) are responsible for ensuring the health and safety of the beneficiary. Support coordination and direct service staff must report all incidents, accidents, or suspected cases of abuse, neglect, exploitation, or extortion to the on-duty supervisor immediately and as mandated by law to the appropriate agency. Reporting an incident only to a supervisor does not satisfy the legal requirement to report. The supervisor is responsible for ensuring that a report or referral is made to the appropriate agency.

All suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation, or extortion must be reported to the appropriate authorities. (See Appendix C for contact information).

If the beneficiary needs emergency assistance, the worker shall call 911 or the local law enforcement agency.

Any other circumstances that place the beneficiary's health and well-being at risk should also be reported.

SCAs and DSPs are responsible for documenting and maintaining records of **all** incidents and accidents involving the beneficiary. The Office for Citizens with Developmental Disabilities (OCDD) *Critical Incident Reporting, Tracking and Follow-up Activities for Waiver Services* procedures must be followed for all reporting, tracking and follow-up activities of all critical incidents. Non-compliance shall result in administrative actions as indicated in this document. (See Appendix D for information on obtaining a copy of this document).

NOTE: It is the policy of the Louisiana Department of Health (LDH), OCDD that all critical incidents for home and community-based services (HCBS) be reported, investigated and tracked. The statewide incident management system **MUST** be used for **ALL** critical incident reporting.

Internal Complaint Policy

Beneficiaries/guardians must be able to file a complaint regarding services without fear of reprisal. The provider shall have a written policy to handle beneficiary/guardian complaints. In order to ensure that the complaints are efficiently handled, the provider shall comply with the following procedures:

1. Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, the nature of the complaint and the resolution of the complaint;

2. If the complaint is verbal, the provider staff member receiving the complaint must obtain and send all pertinent information in writing to the provider complaint coordinator. If the beneficiary/guardian completes the complaint form, the provider staff will be responsible for sending the form to the provider complaint coordinator;

3. The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within five working days**;

4. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the beneficiary/guardian, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution;

5. The provider's administrator or designee must inform the beneficiary and/or the personal representative of the results of the internal investigation, in writing, and **within 10 working days** of receipt of the complaint; and

6. If the beneficiary/guardian is dissatisfied with the results of the internal investigation regarding the complaint, they may continue the complaint resolution process by contacting the regional OCDD Waiver Services and Supports Office or the local governing entity (LGE) in writing, or by telephone.

If the complainant's name and address are known, the OCDD will notify the complainant **within two working days** that the complaint has been received and action on the complaint is being taken.

Complainant Disclosure Statement

La. R.S. 40:2009.13 – 40:2009.21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the HCBS waiver programs. When the substance of the complaint is furnished to the service provider, it shall not identify the complainant or the beneficiary unless they consents in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

OCDD may determine when the complaint is initiated that a disclosure statement is necessary. If a Complainant Disclosure Statement is necessary, the complainant must be contacted and given an opportunity to withdraw the complaint.

If the complainant still elects to file the complaint, OCDD will mail or fax the disclosure form to the complainant with instructions to return it to the OCDD central office.

Definitions of Related Terms Regarding Incidents and Complaints

The following definitions are used in the incident and complaint process:

1. Abuse – Any of the following acts which seriously endanger the physical, mental, or emotional health and safety of a child, including:

    a. Infliction or attempted infliction, or as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon a child by a parent or by any other person;

    b. Exploitation or overwork of a child by a parent or by any other person; and

    c. Involvement of a child in any sexual act with a parent or with any other person, or the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, or the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code Article 1003, *et seq.*).

2. Allegation of noncompliance - Accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a beneficiary or beneficiaries (La. R.S. 40:2009.14);

3. Complaint - Allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a beneficiary (La. R.S. 40:2009.14);

4. Disabled person/person with disabilities - Person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for their own care or protection;

5. Incident - Any situation involving a beneficiary that is classified in one of the categories listed in this section, or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the beneficiary or affect delivery of waiver services;

6. Minimal harm - Incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary's activities of daily living (ADL) (La. R.S. 40:2009.14); and

7. Trivial report - Account of an allegation that an incident has occurred to a beneficiary or beneficiaries that causes no physical or emotional harm and has no potential for causing harm to the beneficiary or beneficiaries (La. R.S. 40:2009.14).

SUPPORT COORDINATION

Support coordination, which is also referred to as case management, is a waiver service that is provided to all Louisiana Children's Choice (CC) Waiver beneficiaries. Support coordination is an organized system by which a support coordinator assists a beneficiary to prioritize and define their personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Beneficiaries may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies (SCAs) are required to perform the following:

1. Intake;
2. Assessment;
3. Plan of care (POC) development and implementation;
4. Follow-up/monitoring;
5. Reassessment; and
6. Transition/closure.

Intake

Intake serves as an entry point into the CC Waiver and is used to gather baseline information to determine the beneficiary's medical eligibility for waiver services, service needs, appropriateness for services, and desire for support coordination.

Intake Procedures

Referrals for support coordination services are only made from the Office for Citizens with Developmental Disabilities (OCDD) through the Medicaid data management contractor. The applicant must be interviewed to obtain the required demographic information, preferably face-to-face in the applicant's home, within three working days of receipt of the Freedom of Choice (FOC) form.

The POC process begins with an initial face-to-face meeting in the beneficiary's home. The support coordinator requests and gathers medical, social, educational, and psychological documentation necessary to complete the POC.

The local governing entity (LGE) will transfer eligibility documents with the transfer of records to the SCA. Prior authorization (PA) to cover services from the beginning date of the POC will be issued upon approval of the POC.

The support coordinator must determine whether the applicant:

1. Has a need for immediate support coordination intervention; and

2. Is receiving support coordination service or other services from another provider or community resource.

NOTE: If the applicant is receiving support coordination from another OCDD provider, the OCDD state office support coordination program manager must be contacted to correct the linkage. (See Appendix C for contact information).

Applicants who are receiving support coordination from another provider must remain with their current provider until approved for the waiver. Requests to change to a different SCA may be made following waiver certification. Refer to "Changing SCAs" at the end of this section.

The support coordinator must obtain signed release forms and have the applicant/family sign a standardized intake form that documents the applicant/family:

1. Was informed of procedural safeguards;

2. Was informed of their rights along with grievance procedures;

3. Was advised of their responsibilities;

4. Accepted support coordination service;

5. Was advised of the right to change support coordination providers, support coordinators, service providers; and

6. Was advised that waiver services and support coordination service are an alternative to institutionalization.

If the services in the CC Waiver are not appropriate to meet the applicant's needs, or if the applicant does not meet the eligibility requirements for waiver services, the applicant should be notified immediately, given appeal rights, and directed to other service options or to the source of the initial referral.

Assessment

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

Assessment Process

The person-centered support assessment must be conducted by the support coordinator and consist of the following:

1. Face-to-face home interviews with the beneficiary/beneficiary's family or guardian;

2. Direct observation of the beneficiary;

3. Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the beneficiary; and

4. FOC of all services, support coordination and alternative to institutionalization.

Characteristics and components of the assessment include:

1. Identifying information (demographics);

2. The use of a standardized instrument for certain targeted populations;

3. Personal outcomes identified, defined and prioritized by the beneficiary;

4. Medical/physical information;

5. Psycho social/behavioral information;

6. Developmental/intellectual information;

7. Socialization/recreational information including the social environment and relationships that are important to the beneficiary;

8. Patterns of the beneficiary's everyday life;

9. Financial resources;

10. Educational/vocational information;

11. Housing/physical environment of the beneficiary;

12. Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes;

13. Information relevant to understanding the supports and services needed by the beneficiary to achieve the desired personal outcomes, (e.g., input from formal and informal service providers and caregivers as relevant to the personal outcomes); and

14. Identification of areas where a professional evaluation is necessary to determine appropriate services or interventions.

It is the responsibility of the support coordinator to assist the beneficiary to arrange any professional/clinical evaluations that are needed to develop strategies for obtaining the services, resources, and supports necessary to achieve their desired personal outcomes while ensuring beneficiary choice. The support coordinator must identify, gather, and review the array of formal assessments and other documents that are relevant to the beneficiary's needs, interests, strengths, preferences, and desired personal outcomes. A signed authorization must be obtained from the beneficiary or guardian (if the beneficiary is a minor) to secure appropriate services. A signed authorization for release of information must be obtained and filed in the case record.

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

Time Frame for Initial Assessment

The initial assessment must begin **within seven calendar days** and be completed **within 30 calendar days** following the referral/linkage.

Ongoing Assessment Procedures

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

Plan of Care Development and Implementation

The POC is the analysis of information from the formal evaluations and the person-centered supports assessment and is based on the unique personal outcomes identified, defined and prioritized by the beneficiary.

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

The purpose of the POC is to:

1. Establish direction for all persons involved in providing supports and services for the beneficiary by describing how the needed supports and services interact to form overall strategies that assist the beneficiary to maintain or achieve the desired personal outcomes;

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

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

The POC should not be considered a treatment plan of specific clinical interventions that service providers would use to achieve treatment or rehabilitation goals. Instead, the POC should be considered a "master plan" consisting of a comprehensive summary of information to aid the beneficiary to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining the desired personal outcomes.

Required Procedures

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

The POC must be outcome-oriented, individualized, and time limited. The planning process should include tailoring the POC to the beneficiary's needs based on the on-going personal outcomes assessment. It must develop mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports, and appropriate formal paid services. The beneficiary, support coordinator, members of the support system, direct service providers (DSPs), and appropriate professional personnel must be directly involved in the development of the POC.

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

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

The POC must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the beneficiary must be clearly explained. The POC must be approved prior to issuance of any PA.

Required Components

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

1. The beneficiary's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed, paid formal services;

2. Budget payment mechanism, as applicable;

3. Target/resolution dates for the achievement/maintenance of personal outcome;

4. Assigned responsibilities;

5. Identified preferred formal and informal support/service providers and the specific service arrangements;

6. Identified individuals who will assist the support coordinator in planning, building/implementing supports, or direct services;

7. Ensured flexibility of frequency, intensity, location, time, and method of each service or intervention and is consistent with the POC and beneficiary's desired outcomes;

8. Change in a waiver service provider(s) can only be requested by the beneficiary at the end of a 12-month linkage unless there is "good cause." Any request for a change requires a completion of a FOC form. A change in support coordination providers is to be made through the Medicaid data management contractor. A change in DSPs is to be made through the support coordinator;

9. All participants present at the POC meeting must sign the POC;

10. The POC must be completed and approved as per POC instructions; and

11. The beneficiary must be informed of their right to refuse a POC after carefully reviewing it.

Building and Implementing Supports

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

Responsibilities of the support coordinator include:

1. Building and implementing the supports and services as described in the POC;

2. Assisting the beneficiary/family to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the beneficiary in the POC;

3. Being aware of and providing information to the beneficiary/family on potential community resources, including formal resources (Supplemental Nutrition Assistance Program (SNAP) Benefits, Supplemental Security Income (SSI), housing, Medicaid, etc.) and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining their desired personal outcomes;

4. Assisting with problem solving with the beneficiary, supports, and services providers;

5. Assisting the beneficiary to initiate, develop, and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet the beneficiary's individual needs;

6. Advocating on behalf of the beneficiary to assist in obtaining benefits, supports, or services, e.g., to help establish, expand, maintain and strengthen the beneficiary's informal and natural support networks by calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;

7. Training and supporting the beneficiary in self-advocacy, e.g., selection of providers and utilization of community resources to achieve and maintain the desired outcomes;

8. Overseeing the service providers to ensure that the beneficiary receives appropriate services and outcomes as designed in the POC;

9. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and develop creative opportunities; and

10. Meeting with the beneficiary face-to-face in the beneficiary's home between a six and nine-month period and for each annual POC development, or more often if requested by the beneficiary/family.

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

Required Time Frames

1. Linkage:

a. The POC must be completed and received by the LGE within 35 calendar days following the date of the notification of linkage by the data management contractor. All incomplete packages will be returned.

2. Revisions to the POC:

a. Routine changes, such as vacations or when school is not in session, must be submitted 10 working days prior to the change.

3. Emergencies:

a. Emergency changes must be submitted within 24 hours or the next working day following the change.

4. Reviews:

a. The POC must be reviewed between the sixth and ninth month of implementation to ensure that the personal outcomes and support strategies are consistent with the needs of the beneficiary; and

b. The POC must be revised at least annually and/or as needed, and submitted to the LGE no later than 35 days prior to expiration. The POC may be submitted as early as 60 days prior to expiration, provided the form 90-L does not expire prior to the POC expiration date.

Changes in the Plan of Care

If there are significant changes (adding or deleting services) in the way the beneficiary prioritizes their personal outcomes, and/or if there are significant changes in the support strategies or service providers, the support coordinator must revise the POC to reflect these changes. A revision request must be submitted to the LGE for approval on all beneficiaries.

Whenever possible, additional service needs should be anticipated and planned for in the initial/annual POC during the POC meeting. If an unanticipated need is identified 10 or more business days prior to the change, a POC Revision request should be submitted and will be processed within 10 business days. The revision should be marked as "Routine". If an unanticipated need is identified less than 10 business days prior to the needed change, the POC Revision request must be identified as "Urgent", and the additional responsibilities for Provider and Support Coordinator must be assumed. For "urgent" requests, the relevant box must be checked. An urgent need exists when there is an unplanned/unpredictable event which requires

urgent changes(s) to waiver services and/or changes in the service provider. Urgent changes are changes that must begin less than 10 business days from receipt by the LGE.

Initiating a Change in the Plan of Care

The beneficiary/family will contact the support coordinator when a change is required. The support coordinator will call a meeting with the service provider(s) to complete the POC revision form. All participants attending the meeting will sign the POC revision, and it will be submitted to the LGE for approval. The support coordinator will notify the service provider(s) and beneficiary of the approval/disapproval.

NOTE: The annual expiration date of the POC should never change.

Documentation

A copy of the approved POC must be kept at the beneficiary's home, in the beneficiary's case record at the SCA, and in the service provider's files. The support coordinator is responsible for providing the copies.

A copy of the POC must be made available to all staff directly involved with the beneficiary.

Plan of Care Monitoring

Follow-up/monitoring is the mechanism used by the support coordinator to assure the appropriateness of the POC and should be completed monthly, quarterly, and annually following the guidelines and using the Support Coordination Contact Documentation form. Through follow-up/monitoring activity, the support coordinator not only determines the effectiveness of the POC in meeting the beneficiary's needs, but identifies when changes in the beneficiary's status necessitate a revision in the POC. The purpose of the follow-up/monitoring contacts is to determine:

1. If services are being delivered as planned;

2. If services are effective and adequate to meet the beneficiary's needs; and

3. Whether the beneficiary is satisfied with the services.

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

Every calendar month after linkage, the support coordinator must make contact with the beneficiary to address the following:

1. Does the beneficiary/family feel the outcomes are being met;
2. Are the times the services are being provided convenient and satisfactory to the beneficiary/family;
3. Does the beneficiary/family have any problems or changes that may require additional services;
4. Are the providers actually present at the times indicated; and
5. Are the provided services adequate and of good quality?

The beneficiary/family should be informed of the necessity to contact the support coordinator when there are significant changes in beneficiary's status or if problems arise with service providers. A major change in status requires a reassessment. If the change is determined to be a long-term situation, refer to Crisis Provisions.

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

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

1. Desired personal outcomes;
2. Strategies to achieve the outcomes;
3. Effectiveness of the strategies;
4. Obstacles to achieving the desired outcomes;
5. New opportunities; and
6. Developing a new action plan.

Reassessment/Working Plan of Care

Assessment must be ongoing to reflect changes in the beneficiary's life and the changing prioritized personal outcomes over time such as strengths, needs, preferences, abilities, and the beneficiary's resources. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the "working" POC.

A reassessment is required when a major change occurs in the status of the beneficiary, the beneficiary's family, or the beneficiary's prioritized needs. A reassessment must be completed **within seven calendar days** of notice of a change in the beneficiary's status.

NOTE: The beneficiary/family may request a complete POC review by the LGE at any time during the POC year if it is felt the POC is unsatisfactory or is inadequate in meeting the beneficiary's service needs.

Six-Month Reassessment

Between six and nine months after POC implementation, the support coordinator shall review the POC with the beneficiary to determine if the needs of the beneficiary continue to be addressed.

Annual Reassessment

A completed annual reassessment package must be received by the LGE no later than **35 calendar days**, but as early as **60 calendar days,** prior to expiration of the POC, provided the form 90-L does not expire prior to the POC expiration date. Incomplete packages will not be accepted. Support coordinators will be responsible for retrieving incomplete packages from the LGE. Sanctions will be applied.

SCA Approval Authority of the Annual Plan of Care

Support coordinators have limited POC approval authority as authorized by OCDD. Approval of a POC for an annual reassessment shall be limited to those cases where:

1. The beneficiary's health and welfare can be assured;
2. There are no changes in waiver services; and
3. The current waiver services are meeting the needs of the beneficiary.

NOTE: All necessary documentation must be submitted to the LGE with a copy of the approved POC.

Support coordinators **do not** have authority to approve a POC when any of the following occurred during the previous POC year:

1. Skilled nursing care;

2. Direct service worker (DSW) given delegation for medication administration or delegation for a complex or non-complex task;

3. Crisis or non-crisis designation was requested;

4. There were three or more critical incident reports during the POC year; or

5. There was any report with a substantiated investigation to the Department of Children and Family Services' (DCFS) Child Welfare Division or the Louisiana Department of Health's (LDH's) Adult Protective Services.

Transition/Closure

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

Closure Criteria

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

1. The beneficiary requests termination of services;

2. Death;

3. Permanent relocation of the beneficiary out of the service area (transfer to another region) or out of state;

4. Long term admission to an institution or nursing facility;

5. The beneficiary requires a level of care (LOC) beyond that which can safely be provided through waiver services; or

6. Beneficiary refuses to comply with support coordination.

Procedures for Transition/Closure

The support coordinator must provide assistance to the beneficiary and to the receiving agency during a transition to assure the smoothest possible transition. Transition/closure decisions should be reached with the full participation of the beneficiary/family. Support coordinators must:

1. Notify the beneficiary/family immediately if the beneficiary becomes ineligible for services;

2. Complete a final written reassessment identifying any unresolved problems or needs and discuss methods of negotiating their own service needs with the beneficiary/family ;

3. Notify the service provider(s) immediately if services are being transitioned or closed; and

4. Assure the receiving agency, program or support coordinator receives copies of the most current POC and related documents.

NOTE: The form 148-W must be completed to reflect the date on the transfer of records and submitted to LGE.

The SCA must:

1. Notify the LGE of the transition/closure four weeks prior to the closure to allow the LGE time to establish a transition plan;

2. Follow their own policies and procedures regarding intake and closure; and

3. Serve as a resource to beneficiaries who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities. All closures must be entered into the database immediately.

NOTE: An agency shall not close a beneficiary's case that is in the process of an appeal. Only upon receipt of the appeal decision may the case be closed. If an appeal is requested within ten days, the case remains open. If not requested within ten days, the case will be closed.

The agency shall not retaliate in any way against the beneficiary for terminating services or transferring to another agency for support coordination services.

Transition at Age 21

When the beneficiary reaches age 21, as long as they remain eligible for waiver services, they will transfer to an appropriate home and community-based services (HCBS) waiver for adults who meet the LOC requirements for an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Support coordinators must begin the transition process no less than 90 days prior to the beneficiary's 21st birthday and submit the transition plan to the LGE no less than 35 days prior to the beneficiary's 21st birthday.

Changing Support Coordination Agencies

When a beneficiary selects a new support coordination provider, the data management contractor will link the beneficiary to the new provider. The new support coordination provider must:

1. Complete the FOC file transfer;
2. Obtain the case record and authorized signature; and
3. Inform the transferring SCA.

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

1. Most current POC;
2. Current assessments on which the POC is based;
3. Number of services used in the calendar year;
4. Most recent six months of progress notes; and
5. Form 90-L.

The transferring support coordination provider shall provide services up to the transfer of the records and is eligible to bill for support coordination services after the dated notification is received (transfer of records) by the receiving agency. In the month the transfer occurs, the receiving agency shall begin services within three days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. The receiving agency must submit the required documentation to the LGE/and the Medicaid data management contractor to begin PA immediately after the transfer of records.

Other Support Coordination Responsibilities

Coordination of Family Support and Personal Care Services

The personal care service (PCS) provider must submit information to the Medicaid fiscal intermediary (FI) for PA. Support coordinators will send a copy of the PCS PA to the family support provider (if different from the PCS provider) to ensure that service times are not overlapping. Clear documentation of each service is required in the family support and PCS providers' files. (See Appendix D for information on obtaining the "Comparison Chart Louisiana Children's Choice Family Support – PCA & EPSDT-PCS").

Assistance with Self-Direction Option

Support coordinators are responsible for providing assistance to beneficiaries who select to participate in the self-direction option with the following activities:

1. Training beneficiaries on their responsibilities as an employer;
2. Completing required forms for participation in the self-direction option;
3. Assisting with development of the back-up service plan;
4. Assisting with development of budget planning;
5. Verifying potential employees meet program qualifications;
6. Ensuring the beneficiary's needs are being met through services; and
7. Monitoring the beneficiary's self-directed services each quarter.

Reporting of Incidents, Accidents, and Complaints

The support coordinator must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OCDD, HSS, and other appropriate agency as mandated by law. All suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion must be reported to the appropriate authorities. Refer to Section 14.10 – Incidents, Accidents and Complaints for additional instructions.

SELF-DIRECTION OPTION

Self-direction is a voluntary service delivery option in the Children's Choice (CC) Waiver that allows beneficiaries to coordinate the delivery of waiver services through an individual direct support professional rather than through a licensed, enrolled provider agency. The beneficiary becomes the employer of the direct service workers (DSWs) selected to provide the supports, and as the employer, the beneficiary or their authorized representative is responsible for recruiting, training, supervising and managing the DSWs who have been hired.

A required component of the self-direction option is the use of a fiscal/employer agent (F/EA) to perform the beneficiary's employer-related financial management services (FMS). Beneficiaries must utilize support coordination services for the development of the plan of care (POC), budget planning, ongoing evaluation of supports and services, and for organizing the unique resources the beneficiary needs.

Refer to the Fiscal/Employer Agent (F/EA) Manual for additional information.

Support coordination services are also required for the development of the POC, budget planning, ongoing evaluation of supports and services, and for organizing the various resources the beneficiary needs.

Beneficiary Responsibilities

Beneficiaries participating in this option must:

1. Be a CC Waiver beneficiary;

2. Understand the rights, risks, and responsibilities of managing their own care, and managing and using an individual budget, or if under 18 years of age or unable to make decisions independently, have a willing decision maker (authorized representative who is listed on the beneficiary's POC) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within the individualized budget;

3. Be able to participate in this option without a lapse or decline in quality of care or an increased risk to their health and welfare;

4. Adhere to the health and welfare safeguards identified by the team, including the application of a comprehensive monitoring strategy and risk assessment and management systems;

5. Participate in the development and management of the approved budget:

    a. The annual budget is determined by the recommended service hours listed in the beneficiary's POC to meet their needs; and the

    b. Beneficiary's individual budget includes a potential amount of dollars within which the beneficiary or their authorized representative exercises decision-making responsibility concerning the selection of services and service providers;

6. Complete the mandatory training including rights and responsibilities of managing their own services and supports and individual budget offered by the support coordinator; and

7. Follow all the rules and requirements pertaining to self-direction as outlined in the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD) Self-Direction Option Employer Handbook.

The employer must be at least 18 years of age. The authorized representative may be the employer of the self-directed option, but may not also be the employee.

NOTE: Direct care services workers must be at least 18 years of age on the date of hire and complete all mandated training.

Self-Direction Services

All services must be:

1. Prior authorized in accordance with the POC prior to being rendered; and

2. Documented in the service notes. Service notes shall describe the services rendered and progress towards the beneficiary's personal outcomes POC.

Termination of the Self-Direction Service Option

Termination of participation in the self-direction service delivery option requires a revision of the POC, the elimination of the fiscal agent and adding the beneficiary's choice of a Medicaid-enrolled waiver service provider(s). Termination may be either voluntary or involuntary.

Voluntary Termination

Beneficiaries utilizing the self-direction option can choose to return to traditional provider services at any time. The support coordinator will assist the beneficiary in transitioning to a service provider agency.

Involuntary Termination

Involuntary dismissal from the self-direction option may occur if:

1. OCDD determines that the health or welfare of the beneficiary is compromised by continued participation in the self-direction service delivery option;

2. There is evidence that the beneficiary is no longer able to direct their care, and there is no authorized representative to direct the care;

3. Over three payment cycles in a one-year period, the beneficiary or the authorized representative:

    a. Places barriers to the payment of the salaries and related employment taxes of direct support staff;

    b. Fails to follow the approved budget;

    c. Fails to provide the required documentation of expenditures and related items; or

    d. Fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures.

4. There is proof of misuse of public funds by the beneficiary or responsible representative.

DEVELOPMENTAL DISABILITY LAW

A developmental disability is defined by the Developmental Disability Law (Louisiana Revised Statutes 28:451.1-28:455.2). The law states that a developmental disability means either:

1. A severe chronic disability of a person that:

2. Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;

3. Is manifested before the person reaches age 22;

4. Is likely to continue indefinitely;

5. Results in substantial functional limitations in three or more of the following areas of major life activity:

    a. Self-care;

    b. Receptive and expressive language;

    c. Learning;

    d. Mobility;

    e. Self-direction;

    f. Capacity for independent living; and

    g. Economic self-sufficiency.

6. Is not attributed solely to mental illness;

7. 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

8. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high

probability of resulting in those criteria listed above later in life that may be considered to be a developmental disability.

GLOSSARY

The following is a list of abbreviations, acronyms and definitions used in the Children's Choice (CC) Waiver manual chapter.

Abuse (Adult/Elderly) – The infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, 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 15:1503)

Abuse (Child) – Any of the following that seriously endanger the physical, mental or emotional and safety of the child including:

1. The infliction or attempted infliction, or as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon the child by a parent or by any other person;

2. The exploitation or overwork of a child by a parent or by any other person; and

3. The involvement of a child in any sexual act with a parent or with any other person, or the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, or the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code, Article 603).

Activities of Daily Living (ADL) – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility, and eating. The extent to which a person requires assistance to perform one or more ADL often is a level of care (LOC) criterion.

Advocacy – The process of ensuring that beneficiaries receive appropriate, high quality services and locating additional services needed by the beneficiary which are not readily available in the community.

Appeal – A due process system of procedures that ensures that a beneficiary will be notified of and have an opportunity to contest a Louisiana Department of Health (LDH) decision.

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

Assessment – One or more processes that are used to obtain information about a person, including their condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information

supports the determination that a person requires waiver services as well as the development of the plan of care (POC).

Authorized Representative – A person designated by a beneficiary (by use of a designation form) to act on their behalf with respect to their services.

Beneficiary – An individual who has been certified for medical benefits by the Medicaid Program. A Beneficiary certified for Medicaid waiver services may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within LDH responsible for the administration of the Louisiana Medicaid Program.

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) programs.

Claim – A request for payment for services rendered.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a beneficiary (La. R.S. 40:2009.14).

Confidentiality – The process of protecting a beneficiary's or an employee's personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and by Louisiana law.

Corrective Action Plan – Written description of action a direct service provider (DSP) agency plans to take to correct deficiencies identified by the Local Governing Entity (LGE), Office for Citizens with Developmental Disabilities (OCDD), or LDH.

Critical Incident – An alleged, suspected or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.

De-certification – Removal of a beneficiary from the waiver by OCDD due to the inability of waiver services to ensure a beneficiary's health and safety in the community or due to non-compliance with waiver requirements by the beneficiary. Decertification of a waiver beneficiary is subject to review by the State Office Review panel prior to notification of appeal rights and subsequent termination of waiver services.

Developmental Disability – See Appendix A.

Diagnosis and Evaluation – A process conducted by an appropriate professional to determine a person's level of disability and to make recommendations for remediation.

Direct Service Provider (DSP) – A public or private licensed organization/entity that is enrolled as a Medicaid provider to furnish services to beneficiaries using its own employees (direct support workers (DSWs)).

Direct Support Worker (DSW) – A non-licensed person who is paid to provide direct services and active supports to a beneficiary.

Discharge – A beneficiary's removal from the waiver for reasons established by OCDD.

Durable Medical Equipment (DME) – Covered medical equipment or supplies that have been prescribed and prior authorized under the Medicaid State Plan.

Eligibility – The determination of whether or not a person qualifies to receive waiver services based on meeting established criteria for the target group as set by LDH.

Electronic Visit Verification (EVV) – A computer based system that records the actual time the provision of waiver services begins and ends. Louisiana Service Reporting System (LaSRS®) is the state sponsored system that is mandatory for some waiver services, as identified in the program manual. Providers may request permission from BHSF and OCDD to use their own. EVV system for mandatory services. Approval will only be granted for EVV systems that meet minimum standards established by the department.

Emergency Backup Plan – Provision of alternative arrangements for the delivery of services that are critical to a beneficiary's well-being in the event that the DSW responsible for furnishing the services fails or is unable to deliver them.

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 the person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (Louisiana Revised Statutes 15:1503).

Extraordinary Care – Exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

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.

Fiscal/Employer Agent (F/EA) – A term used by the Internal Revenue Service (IRS) for entities that perform tax withholding for employers.

Force Majeure – An event or effect that cannot be reasonably anticipated or controlled.

Freedom of Choice (FOC) – The process that allows a beneficiary the choice between institutional or home and community based services and to review all available support coordination and service provider agencies in order to freely select agencies of their choice.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule – A Federal regulation designed to provide privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals, and other healthcare providers.

Home and Community-Based Services (HCBS) – An optional Medicaid program established under 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 requirement of an institutional level of care. It provides a collection of services through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services. Such facilities must be licensed by LDH's Health Standards Section (HSS).

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A public or private facility that provides health and habilitation services to people with developmental disabilities. ICFs/IID have four or more beds and provide "active treatment" to their residents. Such facilities must be licensed by LDH's HSS.

Individual Budget – An amount of dollars over which the beneficiary or their authorized representative exercises decision-making authority concerning the selection of services, service providers, and the amount of services (self-direction option).

Individualized Service Plan (ISP) – A written agreement developed by a service provider that specifies the long-range goals, short-term objectives, specific strategies or action steps, assignment of responsibility, and timeframes for meeting the beneficiary's personal outcomes as specified in their approved POC.

Institutionalization – The placement of a beneficiary in an inpatient facility including a hospital, group home for people with developmental disabilities, nursing facility, or psychiatric hospital.

Legally Responsible – A parent of a minor child, spouse, curator or continued tutor for an adult.

Level of Care (LOC) – The specification of the minimum amount of assistance that a person must require in order to receive services in an institutional setting under the Medicaid State Plan.

Licensure – A determination by LDH's HSS that a service provider agency meets the requirements of applicable Federal, State, and Local laws to provide services.

Linkage – Act of connecting a beneficiary to a specific support coordination or service provider agency.

Louisiana Department of Health (LDH) – The state agency responsible for administering the state's Medicaid program and other health and related services including, but not limited to, public health, behavioral health, developmental disabilities and addictive disorder services.

Louisiana Rehabilitation Services (LRS) – The agency under the Louisiana Workforce Commission charged with providing vocational rehabilitation services to qualified persons.

Medicaid – A federal-state medical assistance entitlement program provided under a State plan approved under Title XIX of the Social Security Act.

Medicaid Eligibility Determination (Form 90-L) – The form that is signed by a Louisiana licensed physician, advanced practice registered nurse (APRN), or physician assistant and used by Medicaid to establish a LOC. In the CC waiver program, a beneficiary must meet an ICF/IID LOC in order to be offered a waiver opportunity.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by the LDH. (LA RS 14:70.1)

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 beneficiaries.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary's ADL (La. RS 40:2009.14).

Monitoring – The ongoing oversight of the provision of waiver services to ensure that they are furnished according to the beneficiary's POC and effectively meet their needs.

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

Native Language – The language normally used by the beneficiary and their support network, which may include American or English Sign Language and other non-verbal forms of communication.

Natural Supports – Persons who are not paid to assist a beneficiary in achieving their personal outcomes regardless of their relationship to the beneficiary.

Neglect (adult/elderly) – The failure of a care giver who is responsible for an adult's care or by other parties, or by the adult beneficiary's action or inaction to provide the proper or necessary support or medical, surgical, or any other care necessary for their 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 15:1503).

Neglect (child) – The refusal or unreasonable failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment or counseling for any injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired. The inability of a parent or caretaker to provide for a child due to inadequate financial resources shall not, for that reason alone, be considered neglect. Whenever, in lieu of medical care, a child is being provided treatment in accordance with the tenets of a well – recognized religious method of healing which has a reasonable, proven record of success, the child shall not, for that reason alone, be considered to be neglected or maltreated. (Children's Code Article 603).

New Opportunities Waiver (NOW) – A 1915(c) waiver designed to provide home and community-based services to beneficiaries who otherwise would require the LOC of an ICF/IID.

Office for Citizens with Developmental Disabilities (OCDD) – The operating agency responsible for the day-to-day operation and administration of the OCDD Waiver programs.

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

Person-Centered Planning – A POC process directed and led by the beneficiary or their authorized representative designed to identify their strengths, capacities, preferences, needs, and desired outcomes.

Personal Outcomes – Results achieved by or for the waiver beneficiary through the provision of services and supports that make a meaningful difference in the quality of their life.

Plan of Care (POC) – A written plan designed by the beneficiary, their authorized representative, service provider(s), and others chosen by the beneficiary, and facilitated by the support coordinator which lists all paid and unpaid supports and services. It also identifies broad goals and timelines identified by the beneficiary as necessary to achieve their personal outcomes.

Plan of Correction – A plan developed by a provider in response to deficient practice citations. Required components of the Plan of Correction include the following:

1. What corrective actions will be accomplished for those waiver beneficiaries found to have been affected by the deficient practice;

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

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

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

Pre-Certification Visit – The visit the OCDD Regional Waiver Supports and Services Office or LGE makes to the residence of the applicant, where at a minimum the applicant and, if appropriate, their 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.

Prior Authorization (PA) and Post Authorization – The authorization for service delivery based on the beneficiary's approved POC. PA must be obtained before any waiver services can be provided and post authorization must be approved before services delivered will be paid.

Procedure Code – A code used to identify a service or procedure performed by a provider.

Provider/Provider Agency – An individual or entity furnishing Medicaid services under a provider and/or licensing or certification agreement.

Quality Assurance/Quality Enhancement (QA/QE) Program: - A 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 and special studies.

Quality Improvement (QI) – The performance of discovery, remediation, and quality improvement activities in order to ascertain whether the service provider agency meets assurances, corrects shortcomings, and pursues opportunities for improvement.

Quality Management – The section within the OCDD whose responsibilities include the activities to promote the provision of effective services and supports on behalf of beneficiaries 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 POC.

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 beneficiary.

Request for Services Registry (RFSR) – A registry maintained by the OCDD that includes the dates of request and the names of individuals who have been determined to meet the Louisiana definition for developmental disability and wish to receive services through OCDD

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 (Louisiana Revised Statutes 15:1503).

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

Single Point of Entry (SPOE) – The OCDD regional offices, LGEs, where the entry point for all developmental disability services, including HCBS waivers, is made.

Statement of Approval (SOA) – Previously known as a Statement of Eligibility (SOE). Statement issued by the SPOE confirming the date the individual has been determined to meet the Louisiana definition for developmental disability.

Support Coordination – Case management services provided to eligible beneficiaries to help them gain access to the full range of needed services including medical, social, educational and other support services. Activities include assessment, POC development, service monitoring, and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources. Support coordination is also referred to as case management. SCAs must be licensed by LDH's HSS.

Support Coordinator – 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 POC, which identifies all services and supports deemed necessary for the beneficiary to remain in the community as an alternative to institutionalization.

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

Surveillance Utilization Review System (SURS) – The program operated by the LDH Fiscal Intermediary (FI) in partnership with the Program Integrity Section, which reviews provider's compliance with Louisiana Medicaid policies and regulations, including investigating allegations of excessive billing.

Title XIX – The section of the Social Security Act, which authorizes the Medicaid Program.

Transition – The steps or activities conducted to support the passage of the beneficiary from existing formal or informal services to the appropriate level of services, including disengagement from all services.

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

Waiver Service – An approved service in a HCBS waiver provided to an eligible beneficiary that is designed to supplement, not replace, the beneficiary's natural supports.

CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Office of Citizens with Developmental Disabilities (OCDD) Central Site	Operating agency responsible for the statewide operation and administration of the OCDD waiver programs.	OCDD P. O. Box 3117, Bin #21 Baton Rouge, LA 70821-3117 Phone: (225)342-0095 Toll-Free: 1-866-783-5553 Fax: (225)342-8823
Human Service Districts and Authorities	Regional office responsible for Single Point of Entry, implementation and oversight of the ROW on behalf of OCDD.	https://ldh.la.gov/page/134
Louisiana Department of Health (LDH) – Health Standards Section (HSS)	Office to contact to report changes that affect provider licenses.	LDH - HSS P. O. Box 3767 Baton Rouge, LA 70821 Phone: (504)342-0138 Fax: (225)342-5073
Division of Administrative Law - LDH	Office to contact to file an appeal request.	Department of Administrative Law - LDH P. O. Box 4033 Baton Rouge, LA 70804 Phone: (225)342-1800 Fax: 92250342-1812
Gainwell Technologies Provider Enrollment Section	Office to contact to report changes in agency ownership, address, telephone number or account information affecting electronic funds transfer.	Gainwell Technologies Provider Enrollment Section P.O. Box 80159 Baton Rouge, LA 70898 Phone: (225)216-6370
Gainwell Technologies Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information.	Gainwell Technologies Provider Relations Unit P.O. Box 91024 Baton Rouge, LA 70821 Phone: 1-800-473-2783 or (225)924-5040

Healthy Louisiana (Medicaid Managed Care Organizations (MCOs))	Healthy Louisiana (previously called Bayou Health) is the way most of Louisiana's Medicaid and LACHIP participants receive health care services. In Healthy Louisiana, Medicaid participants enroll in a managed care plan.	https://ldh.la.gov/healthy-louisiana
Medicaid Program Integrity	Office to contact to report Medicaid fraud, waste or abuse.	Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://ldh.la.gov/index.cfm/page/219
Louisiana State Adverse Actions List Search with Direct Service Worker (DSW) Registry Information **and** **Office of the Inspector General (OIG)**	Verification of exclusion or restriction from government funded health program and verification of findings which excludes DSW from working with waiver participants. **NOTE:** Provider MUST search both for each worker upon hire and every month thereafter and must maintain documentation of these checks.	https://adverseactions.ldh.la.gov/SelSearch and https://exclusions.oig.hhs.gov/
Federal System Award Management	Verification of exclusion or restriction of vendors from government funded programs. **NOTE:** Provider MUST search upon hire and every month thereafter and must maintain documentation of these searches.	https://sam.gov/
Department of Children and Family Services (DCFS) – Local Child Protection Hotline	Office to contact to report suspected cases of abuse, neglect, exploitation, or extortion of a beneficiary under the age of 18.	https://dcfs.louisiana.gov/
Myers and Stauffer's, LLC	Information about filing cost reports.	https://myersandstauffer.com/client-portal/louisiana/

Statistical Resources, Inc.	Entity to contact regarding: LaSRS, Electronic Visit Verification (EVV), Prior/Post Authorizations, and Billing Issues.	11505 Perkins Road Suite H Baton Rouge, LA 70810 Phone: (225)767-0501

Office for Citizens with Developmental Disabilities

Contact information for the central office and the Human Services Authorities and Districts is found on the OCDD website at: https://ldh.la.gov/office-for-citizens-with-developmental-disabilities.

APPENDIX D

This section contains a list of the forms, handbooks and other documents that are used in the Children's Choice (CC) Waiver program and the websites where they can be obtained.

The following forms can be obtained from http://ldh.la.gov/index.cfm/newsroom/detail/1564:

1. Environmental Accessibility Adaptation Flow Chart;
2. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Personal Care Services (PCS) vs. Home Health Services;
3. Comparison Chart Louisiana CC Waiver Family Support – PCA & EPSDT-PCS;
4. Comparison Chart – Between CC Waiver and the New Opportunities Waiver (NOW);
5. Emergency Protocol for Tracking Location Before, During and After Hurricanes;
6. Request for Crisis Designation Flow Chart;
7. Universal Plan of Care (POC) for CC Waiver;
8. Instructions for the Comprehensive Plan of Care (CPOC) Revision Request;
9. CC Waiver Universal POC Revision Request;
10. Louisiana CC Waiver Request for Family Training;
11. Louisiana CC Waiver Request for Crisis Designation Form;
12. Environmental Accessibility Adaptation Job Completion Form;
13. Louisiana CC Waiver Request for Non-Crisis/Other Good Cause Criteria Designation;
14. Beneficiary's Consent for Authorized Representation; and
15. Rights and Responsibilities for Individuals Requesting or Receiving Home and Community-Based Services (HCBS).

Providers are also required to follow the procedures outlined in the following document:

1. The *Quality Enhancement Provider Handbook.* This document can be obtained from the Louisiana Department of Health (LDH) website at: http://ldh.la.gov/assets/docs/OCDD/waiver/QEProviderHandbook080108.pdf

Information about the reporting of critical incidents can be obtained from the LDH website at:

1. http://ldh.la.gov/assets/docs/OCDD/Critical-Incident-Reporting/OCDDC_HCBSCriticalIncidentReportFillableForm7.31.19.pdf

CHILDREN'S CHOICE WAIVER
SERVICES PROCEDURE CODES/RATES
NOTE: Children's Choice Waiver Cap = $20,650
Services should not exceed waiver-capped amount

Provider Type	HCBS Waiver Service Description	HIPAA Code	Modifier	HIPAA Service Description	Units
45	Children's Choice (CC) Waiver Support Coordination	T2022		CC Waiver Support Coordination	Monthly $162.50
03	Crisis Support	H2011		Crisis Intervention	15 minutes $3.88
03	Family Support	S5125		Attendant Care Services	15 minutes $4.38
03	Center Based Respite	T1005	HQ	Respite Care	15 minutes $3.38
03	Family Training	S5111		Home Care Training-Family	Based on Comprehensive Plan of Care (CPOC) Funds Availability
03	Ramp-Home	S5165	U4	Home Modifications	
03	Bathroom Modifications	S5165	U5		
03	General Adaptations-Home	S5165			
03	Vehicle Lifts	T2039		Vehicle Modifications	
03	Specialized Medical Equipment and Supplies (Lifts)	E0630		Medical Equipment and Supplies	
03	Specialized Medical Equipment and Supplies (Switches)	E2322			
03	Specialized Medical Equipment and Supplies (Controls)	E2321			
03	Specialized Medical Equipment and Supplies (Others)	K0900			
03	Specialized Medical Equipment and Supplies (Routine maintenance and repair)	T2029	RB		
03	Remote Supports	S5162		Emergency Response System Purchase	
03	Remote Supports	T1028		Home Environment Assessment	$450.00
03	Remote Supports	S5185		Medication Reminder Service Per month	$75.00
03	Remote Supports	A9279		Monitoring feature/device noc	

Provider Type	HCBS Waiver Service Description	HIPAA Code	Modifier	HIPAA Service Description	Units
03	Remote Supports	A9279	GT	Monitoring feature/device noc interactive audio and video	
03	Remote Supports	A9280		Alert device, noc	
03	Crisis Support – Two Children	H2011	UN	Crisis Intervention	15 minutes $2.76
03	Family Support – Two Children	S5125	UN	Attendant Care Services	15 minutes $3.01
03	Crisis Support – Center Based	H2011	HQ	Crisis Intervention	15 minutes $2.44
WT	Aquatic Therapy	97113		Physical Therapy (Therapeutic Activities)	$21.25/ 15 min $85/ Hr.
AP	Art Therapy	H2032		Therapeutic Activities 1-3	$13.75/ 15min/ $55/hr.
AP	Art Therapy	H2032	HQ	Therapeutic Activities 4+	$9.08/15min $36.32/hr.
MT	Music Therapy	G0176		Therapeutic Activities 1-3	$13.75/ 15min $55/hr.
MT	Music Therapy	G0176	HQ	Therapeutic Activities 4+	$9.08/15min $36.32/hr.
35/37	Sensory Integration	97533		PT/OT Therapeutic Activities	$23.92/15min $95.68/hr.
HT	Hippotherapy	S8940		PT/OT/ST Therapeutic Activities	$21.25/15 min $85/hr.
TH	Therapeutic Horseback Riding	97799		Therapeutic Activities	$9.38/15min $37.52/hr.
AW	Housing Stabilization	G9012		Permanent Supportive Housing	$15.11/15 Min. $60.44/ hr.
AW	Housing Stabilization Transition	G9012	U8	Permanent Supportive Housing	$15.11/15 Min. $60.44/ hr.
01	Financial Management Service (FMS) Self-Direction Option	W7319		FMS Monthly Administrative Fee	$105.88

The specified modifier is required for this Health Insurance Portability and Accountability Act (HIPAA) code.

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

HQ = Group Setting UN = 2 people U4 = ramp U5=bathroom

NOTE: Planning of services is crucial for CC Waiver participants, over utilization of services does not constitute necessity for Crisis Designation.

CLAIMS FILING

Hard copy billing of waiver services are billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **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, or will be denied through the system. 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 that follow.

Paper claims should be submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or

2. The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

NOTE: Electronic claims submission is the preferred method for billing. (See the Electronic Data Interchange (EDI) Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "Health Insurance Portability and Accountability Act (HIPAA) Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing the CMS-1500 claim form and samples of completed CMS-1500 claim forms; and

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS-1500 claim forms.

CMS-1500 (02/12) Instructions for Waiver Services

In order to access the CMS-1500 (02/12) Instructions for Waiver Services and to view sample forms, use the following link: https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500.htm.

NOTE: You must write "WAIVER" at the top center of the claim form.

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted – not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice (RA), a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; or

2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Beneficiary/Patient Identification

Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the RA under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the RA.

Sample forms are on the following pages.

SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE (DATES ON OR AFTER 10/01/15)

WAIVER

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9876543210123

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

3. PATIENT'S BIRTH DATE MM DD YY: 07 31 72 | SEX: M X F

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

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

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

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

CITY | STATE

8. RESERVED FOR NUCC USE

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: TPL Code if applicable

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO If yes, complete items 9, 9a and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. G5 10 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE: A02 ORIGINAL REF. NO.: 5299198798700

23. PRIOR AUTHORIZATION NUMBER: Prior Auth#

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	10	08	15	10	08	15	12		S5125	UN		A	90 00	30		NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

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

28. TOTAL CHARGE $ 90 00

29. AMOUNT PAID $

30. BALANCE DUE $ 90 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.)
SIGNED Ima Biller DATE 10/15/15

32. SERVICE FACILITY LOCATION INFORMATION
a. b.

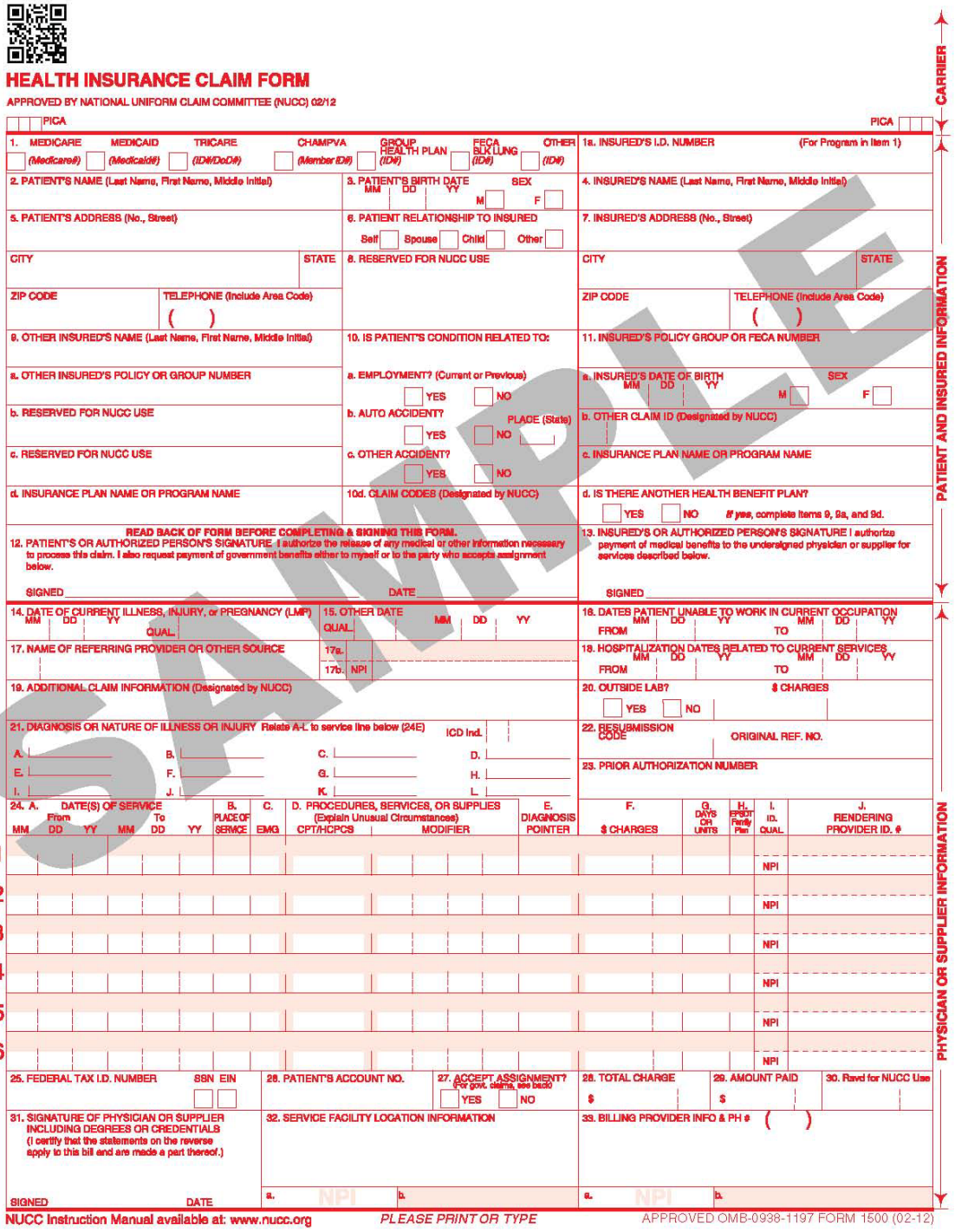
33. BILLING PROVIDER INFO & PH# (225) 555-4957
HERE FOR YOU WAIVER
200 MAIN ST
ANY TOWN, LA 70000
a. 123967654 b. 1239876

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE
EXAMPLE OF ICD 10

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. 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										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 $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE