REIMBURSEMENT

Reimbursement for Community Choices Waiver services vary based on the type of service being provided. Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. (Refer to Appendix C in this manual chapter for information about procedure code, unit of service and current reimbursement rate).

Reimbursement shall not be made for Community Choices Waiver services provided prior to approval of the plan of care and release of prior authorization for the services.

The Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR-433.139. Failure by the provider to exhaust all third party payer sources may subject the enrolled agency/provider to recoupment of funds previously paid by Medicaid. Third parties include, but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare.

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

Refer to Appendix D of this manual chapter for information about claims filing.

Support Coordination

Support coordination is reimbursed at an established monthly rate (see to Appendix C – Billing Codes). The data contractor issues a monthly authorization to the support coordination agency. After the support coordination requirements are met and documented in the case management database, the authorization is released to the support coordination agency. For each quarter in the recipient's plan of care (POC) year, if the support coordination agency does not meet all of the requirements for documentation in the case management database, the prior authorization (PA) for the last month of that quarter will not be released until all requirements are met, and the "Request for Payment/Override Form" has been completed and submitted to the office of Aging and Adult Services (OAAS) Regional Office for approval.

Transition Intensive Support Coordination

Transition Intensive Support Coordination (TISC) is reimbursed at an established monthly rate (see to Appendix C – Billing Codes), for a maximum of six months (not to exceed 180 calendar days) from the POC approval date so long as the participant is residing in the nursing facility. Payment will not be authorized until the data contractor receives an approved POC indicating that the individual was/is a nursing facility resident during the period in which prior authorization is requested.

Transition Services

Transition services are reimbursed only for the exact amount of expenditures indicated on final approval and supporting documentation. Only one authorization for transition services is issued. The authorization period is the effective date of the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the "Transition Services Form (TSF)" are sent to the data contractor. (See Appendix B for a copy of this form).

The support coordination agency is then notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

The OAAS Regional Office, or its designee, shall maintain documentation, including each individual's TSF with original receipts and copies of canceled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes.

Billing for transition services must be completed within 60 calendar days after the individual's actual move date in order for the reimbursement to be paid.

NOTE: If the individual is not approved for CCW services and/or does not transition, but transition service items were purchased, the OAAS Regional Office must notify the OAAS State Office to allow for possible reimbursement.

If it is determined that additional items are needed after the TSF was approved, and there are remaining transition funds in the individual's budget, the support coordinator must submit another TSF within 90 calendar days after the individual's actual move date. The same procedure outlined above shall be followed for any additional needs.

NOTE: If it is determined that the individual has additional needs that were not identified, or billing was not able to occur, within the above established timelines, the OAAS Regional Office must notify OAAS State Office to review for exception.

Environmental Accessibility Adaptation

Environmental Accessibility Adaptation (EAA) services are reimbursed in the amount authorized in the POC or POC revision. The EAA assessor must approve the completion of the modification prior to the provider submitting billing. If for some reason the EAA assessor is unable to perform this function, the OAAS Regional Office must provide approval prior to the provider submitting

billing. The PA is released upon completion and submission of the EAA Form by the support coordinator.

Personal Assistance Services

Personal Assistance Services (PAS) providers are reimbursed at a per quarter-hour-rate for services provided under a Prospective Payment System (PPS) that recognizes and reflects the cost of direct care services provided.

Release of PA for PAS is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. EVV is mandatory for PAS. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OAAS. The system is to be used to electronically "check in" and "check out" when the PAS worker begins and when they end service delivery for a participant.

While there may be some circumstances that require manual edits by the provider's designee, these should only be occasional. In the event that there is a billing overlap, the provider that uses the EVV system correctly (i.e. data has not been manually added or edited) will have priority for payment.

Providers who are approved to provide services to more than one recipient under shared personal assistance services must bill separately for each recipient based on his/her POC. Each recipient must be present to receive the shared services in order for the provider to bill for the service.

Adult Day Health Care

Adult Day Health Care (ADHC) providers are reimbursed at a per quarter-hour-rate for services provided under a Prospective Payment System (PPS) that recognizes and reflects the cost of direct care services provided.

The use of the Electronic Visit Verification (EVV) system is mandatory for ADHC services. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OAAS. The system is to be used to electronically "check in" and "check out" waiver participants when they arrive and when they leave the ADHC center. While there may be some circumstances that require manual edits, these should only be occasional.

The transportation component of ADHC is exempt from this mandatory EVV requirement. However, using the EVV system to electronically record when recipients get on/off the ADHC transportation vehicle may be beneficial to the ADHC provider in preventing overlaps with in-home services and for cost reporting.

In the event of an overlap, the provider that uses the EVV system (i.e. data has not been manually added or edited) will have priority for payment.

Caregiver Temporary Support Services

For providers of overnight Caregiver Temporary Support Services (CTSS), the PA start date will be the morning after the first night of service, and the prior authorization end date will be the morning after the last night of service. Providers may bill for the service after the service has been delivered.

In-home, ADHC, and center based caregiver temporary support (not overnight) requires post authorization by way of EVV.

Monitored In Home Caregiving

Reimbursement for the monitored in-home caregiving (MIHC) intake and assessment is based on a set fee. The PA is released once the MIHC Services Form has been completed and submitted to the data contractor by the support coordinator.

Reimbursement for daily MIHC services is based upon a two-tiered model based on the results of the recipient's assessment.

Tier Level	RUG Categories
Tier 1	Special Rehabilitation • 1.21 • 1.12 • 1.11
	Special Care • 3.11
	Clinically Complex • 4.31 • 4.21
	Impaired Cognition • 5.21

Tier Level	RUG Categories
	Behavior Problems • 6.21
	Reduced Physical Function • 7.41 • 7.31
Tier 2	Extensive Service • 2.13 • 2.12 • 2.11
	Special Care • 3.12

The MIHC provider may bill for services after service delivery.

Assistive Devices and Medical Supplies (AD/MS)

Reimbursement for the Personal Emergency Response System (PERS) is based on a set installation fee and a monthly maintenance fee. The PERS provider may bill for services after they are delivered.

Reimbursement for Telecare includes a one-time installation fee that covers the cost of equipment installation and removal. A monthly maintenance fee includes a face-to-face visit by a qualified professional should the collected data warrant a visit. Should the recipient require additional visits during the month, those visits must be conducted by a nurse, authorized by the support coordinator and provided under Nursing Service. If the data indicates a potential emergency, the provider may dispatch a qualified professional without consultation for approval with the support coordinator; however, the support coordinator must be contacted by the next business day to request retroactive approval.

Billing for PERS or telecare services involves an installation fee and a monthly maintenance fee. Only one claim for each month is allowed. Claims may be span-dated at the discretion of the provider. Partial months shall not be billed.

If a recipient who receives PERS or telecare service moves to a different location or changes providers, reimbursement for a second installment is permissible.

Home Delivered Meals

Reimbursement for meals must not exceed the set rate. The provider uses the PA to bill for services after the meals have been delivered.

Providers may span date bill for up to a two weeks supply of meals.

Nursing Services

Providers of nursing services are reimbursed at a set rate per visit. The support coordinator will complete and submit the Nursing/Therapy Payment Authorization Form to the data contractor after verifying that the services were delivered. The PA will then be released for payment and the provider may submit billing using the proper PA.

Skilled Maintenance Therapy Reimbursement

Providers of skilled maintenance therapy (SMT) are reimbursed at a set rate per visit. The support coordinator will complete and submit the Nursing/Therapy Payment Authorization Form to the data contractor after verifying that the services were delivered. The PA will then be released for payment and the provider may submit billing using the proper PA number.

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

These services are reimbursed at a set rate and in the amount authorized in the approved POC or POC revision. The provider may bill the Medicaid fiscal intermediary using the proper PA after services have been provided.

Span Date Billing

Specific services may be billed as span-dated. Each line on the claim form must represent billing for a single date of service for those services that cannot be span-dated. The following table identifies which services can or cannot be span-dated:

Services that CANNOT be Span-Dated	Services that CAN be Span-Dated
Environmental Accessibility Adaptation	Support Coordination

Services that CANNOT be Span-Dated	Services that CAN be Span-Dated
Caregiver Temporary Support	Personal Assistance Service (PAS)
Personal Emergency Response System, Installation	Personal Emergency Response System, Monthly Service
Telecare Installation	Telecare Monthly Service
Nursing	Monitored In-Home Caregiving Services
Skilled Maintenance Therapy	Home Delivered Meals
Housing Transition or Crisis Intervention Services	
Housing Stabilization Services	
Adult Day Health Care	

Details about when claims can be filed for individual Community Choices Waiver services can be found in Section 7.5 – Service Access and Authorization of this manual chapter.