COVERED SERVICES

This section provides information about the services that are covered in the Community Choices Waiver program. For the purpose of this policy, whenever reference is made to "individual" or "recipient", this includes that person's responsible representative, legal guardian and/or family member, as applicable, who is assisting that person in obtaining services.

NOTE: Recipients who are approved for Community Choices Wavier services cannot receive Long Term – Personal Care Services (LT-PCS).

Support Coordination

Support coordination, also referred to as case management, is a service designed to assist recipients in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, housing and other services, regardless of the funding source for these services. The core elements of support coordination include the following:

- Intake,
- Assessment,
- Plan of care development and revision,
- Linkage to direct services and other resources,
- Coordination of multiple services among multiple providers,
- Monitoring/follow-up,
- Reassessment,
- Evaluation and re-evaluation of level of care and need for waiver services,
- Ongoing assessment and mitigation of health, behavioral and personal safety risk,
- Responding to participant crisis,
- Critical incident management, and
- Transition/discharge and closure.

Providers of support coordination shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by recipients in receiving direct services.

Providers of support coordination shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen their agency unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The Office of Aging and Adult Services (OAAS) must be immediately notified of the circumstances surrounding a refusal to provide/continue to provide services. This requirement can only be waived by OAAS.

Providers of support coordination must establish and maintain effective communication and good working relationships with providers of services to recipients served by the agency.

Recipients must be given information and assistance in directing and managing their services. When recipients choose to self-direct their waiver services, support coordinators are responsible for informing recipients about:

- Their responsibilities as an employer,
- The coordination of their activities as an employer with the fiscal agent and support coordinator, and
- Their responsibility to comply with all applicable state and federal laws, rules, policies and procedures.

Support coordinators shall be available to recipients for on-going support and assistance in these decision-making areas regarding employer responsibilities. (See Appendix B for information on accessing the *"Louisiana Department of Health and Hospitals Office of Aging and Adult Services Self-Direction Option Community Choices Waiver Employer Handbook"*)

Standards

Providers of Community Choices Waiver support coordination must be:

- Certified by the Department of Health and Hospitals to operate a support coordination agency,
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers Support Coordination, Standards for Participation,

- Sign a performance agreement with OAAS,
- Assure staff attends all training mandated by OAAS,
- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services,
- Comply with all Department of Health and Hospitals and OAAS policies and procedures, and
- Be listed as the provider of choice on the Freedom of Choice (FOC) form.

Reimbursement

Support coordination is reimbursed at an established monthly rate. The data management contractor issues a monthly authorization to the support coordination provider. After the support coordination requirements are met and documented in the Case Management Information System (CMIS), the authorization is released to the support coordination provider. For each quarter in the recipient's Plan of Care year, if the support coordination provider does not meet all of the requirements for documentation in the CMIS, the prior authorization (PA) for the last month of that quarter will not be released until all requirements are met. A unit of service is one month.

Transition Intensive Support Coordination

Transition intensive support coordination (TISC) is a service that assists individuals who are currently residing in nursing facilities to gain access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services.

Support coordinators shall comply with all the requirements described above under "Support Coordination." Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient's approved Plan of Care. (See Appendix F for a complete list of the Community Choices Waiver services available during the transition process)

Standards

Providers of Community Choices Waiver TISC must be:

- Certified by the Department of Health and Hospitals to operate a support

coordination agency,

- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation,
- Sign a performance agreement with OAAS,
- Assure staff attends all training mandated by OAAS,
- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services,
- Comply with all DHH and OAAS policies and procedures, and
- Be listed as the provider of choice on the Freedom of Choice (FOC) form.

Service Exclusions

Providers of support coordination are not allowed to bill for TISC until after the individual has been approved for the Community Choices Waiver.

The scope of TISC shall not overlap with the scope of support coordination; therefore, duplicate billing is not allowed.

Service Limitations

Providers of support coordination may be reimbursed up to six months from the Plan of Care approval date. Reimbursement is contingent upon the support coordinator performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the support coordinator. Providers of support coordination will not receive reimbursement for any month during which no activity was performed and documented in the transition process.

Reimbursement

TISC is reimbursed at a monthly rate as set by Medicaid for a maximum of six months from the Plan of Care approval date prior to the date of transition. Payment will not be authorized until the data management contractor receives an approved Plan of Care indicating that the person was/is a nursing facility resident during the time period in which prior authorization is requested.

Transition Services

Transition services assist an individual, who has been approved for a Community Choices Waiver opportunity, to leave a nursing facility and return to live in the community.

Transition services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for a Community Choices Waiver opportunity and are transitioning from a nursing facility to their own living arrangement in a private residence where the individual is directly responsible for his/her own living expenses. Allowable expenses are those necessary to enable the recipient to establish a basic household, excluding expenses for room and board. These services must be identified and approved in the individual's Plan of Care in accordance with DHH/OAAS policies and procedures.

Transition services include the following:

- Security deposits that are required to obtain a lease on an apartment or house,
- Specific set-up fees or deposits for:
    - Telephone,
    - Electricity,
    - Gas,
    - Water, and
    - Other such necessary housing start-up fees or deposits.
- Essential furnishings to establish basic living arrangements:
    - Living Room – sofa/love seat, chair, coffee table, end table, and recliner,
    - Dining Room – dining table and chairs,
    - Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers, nightstand, comforter, sheets, pillows, lamp, and telephone,
    - Kitchen – refrigerator, stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, dishcloths, towels, and potholders,
    - Bathroom – towels, hamper, shower curtain, and bath mat,
    - Miscellaneous - window coverings, window blinds, curtain rod, washer, dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron, and ironing board, and
    - Moving Expenses – moving company and cleaners (prior to move; onetime expense).

- Health and welfare assurances:
    - Pest control/eradication,
    - Fire extinguisher,
    - Smoke detector, and
    - First aid supplies/kit.

Support coordinators must exhaust all other resources to obtain these items prior to utilizing the waiver.

Standards

Providers of Community Choices Waiver transition services must be:

- Certified by the Department of Health and Hospitals to operate a support coordination agency,
- Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation,
- Sign a performance agreement with OAAS,
- Assure staff attends all training mandated by OAAS,
- Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services,
- Comply with all Department of Health and Hospitals and OAAS policies and procedures, and
- Be listed as the provider of choice on the Freedom of Choice (FOC) form.

Service Exclusions

Transition services do not include the following:

- Monthly rental payments,
- Mortgage payments,

- Food,
- Monthly utility charges, and
- Household appliances and/or items intended solely for diversional/recreational purposes (i.e. television, stereo, computer, etc.).

These services do not constitute room and board. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

Service Limitations

There is a $1,500 lifetime maximum for specific items. Services must be prior approved by the OAAS regional office or its designee and require prior authorization.

NOTE: This is the only waiver service that is not subject to the recipient's annual Plan of Care maximum cost.

These services are available to recipients who are transitioning from a nursing facility to their own private residence where they are directly responsible for their own living expenses. When the recipient transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the recipient.

The purchaser for these items may be the recipient, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, the support coordination agency is the only source that can bill for these services.

Reimbursement

Payment shall not be authorized until the OAAS regional office or its designee gives final Plan of Care approval upon receipt of the "Decision Notice" form from the Medicaid office.

When the final approval is issued, the data management contractor is notified to set up a transition service expense tracking record in the database for the recipient and to release the authorization. The support coordination provider is notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination provider did not initially pay for the pre-approved transition expenses, the support coordination provider 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 "OAAS Transition Services Expense and Planning Approval (TSEPA)" form with original receipts and copies of cancelled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes. (See Appendix B for information about this form)

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

NOTE: If the individual is not approved for Community Choices Waiver 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 TSEPA form was approved, and there are remaining transition service funds in the recipient's budget, the support coordinator must submit another TSEPA form within 90 calendar days after the recipient's actual move date. The same procedure outlined above shall be followed for any additional needs.

Environmental Accessibility Adaptations

Environmental accessibility adaptations (EAA) are those necessary physical adaptations made to the home to reasonably assure the health and welfare of the recipient, or enable the recipient to function with greater independence in the home. Without these necessary adaptations, the recipient would require institutionalization. These services must be provided in accordance with state and local laws governing licensure and/or certification.

There must be an identified need for an environmental accessibility adaptation as indicated by the Minimum Data Set – Home Care (MDS-HC). Once identified by the MDS-HC, a credentialed assessor must:

- Verify the need for the adaptation and
- Draft job specifications including quotes for the adaptation.

Any EAA of $5,000 or more must be approved by the OAAS regional office before proceeding with the adaptation.

The support coordinator must:

- Inform the recipient of the EAA service and all possible costs associated with this service (e.g. EAA basic or complex assessment by a qualified EAA assessor,

Home Health Agency assessment, etc.) and

- Obtain written permission from the landlord prior to proceeding with EAA if the recipient does not own the home.

The EAA assessor must ensure that the environmental accessibility adaptation(s) meets all specifications before payment shall be made to the contractor that provided the environmental accessibility adaptation(s).

The adaptation(s), whether from an original claim, a corrected claim, a re-submitted or revised Plan of Care or claim, must be accepted, fully delivered, installed, and operational in the current Plan of Care year that it was approved, unless otherwise approved by the OAAS or its designee.

Environmental accessibility adaptations include the following:

- Ramps
    - portable
    - fixed
- Lifts
    - porch
    - stair
    - hydraulic
    - manual
    - electronic
- Modifications of bathroom facilities
    - roll shower
    - sink
    - bathtub
    - toilet
    - plumbing
- Additions to bathroom facilities
    - roll shower
    - water faucet controls
    - floor urinal

- bidet
- turnaround space

- Specialized accessibility/safety adaptations/additions

  - door widening
  - electrical wiring
  - grab bars
  - handrails
  - automatic door opener/doorbell
  - voice activated, light activated, motion activated and electronic devices
  - fire safety adaptations
  - medically necessary air filtering device*
  - medically necessary heating/cooling adaptations*
  - other modifications to the home necessary for medical or personal safety.

***A doctor's statement concerning medical necessity for air filtering devices and heating/cooling adaptations is required. The support coordinator must obtain such documentation prior to requesting approval from the OAAS regional office or its designee and must maintain the documentation in the recipient's records.**

Standards

All providers must meet all state and/or local requirements for licensure or certification (such as building contractors, plumbers, electricians, engineers, contractors and assessors/inspectors/approvers), enroll as a Medicaid Environmental Accessibility Adaptation provider, be listed as a provider of choice on the FOC form, comply with DHH rules and regulations, and file claims in accordance with established Medicaid guidelines.

Environmental accessibility adaptation providers can be either an assessor/inspector/approver of the adaptation or a contractor for the adaptation, but cannot serve as both to the same Community Choices Waiver recipient for the same adaptation.

Environmental accessibility adaptation assessors/inspectors/approvers are not required to be licensed; however, the following must be on staff or under contract and have completed a minimum of 25 assessments in their particular area of service:

- Licensed and registered occupational therapist,

- Licensed physical therapist, and

- Rehabilitation engineer credentialed as either an assistive technology professional or a registered environmental technician.

All modifications, adaptations, additions or repairs must be made in accordance with all local and state housing and building codes, and must meet the Americans with Disabilities Act requirements.

Environmental accessibility adaptations shall be authorized only if the recipient's health and welfare can be reasonably assured for the duration of the Plan of Care year.

Service Exclusions

This service is not intended to cover basic construction costs. For example, in a new home, a bathroom is already part of the building costs and waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

The following adaptations are not included in this service:

- General house repairs,
- Flooring (carpet, wood, vinyl, tile, stone, marble, etc.),
- Interior/exterior walls not directly affected by an adaptation,
- Lighting or light fixtures that are for non-medical use,
- Furniture,
- Vehicle adaptations,
- Roofing, initial or repairs. This also includes covered ramps, walkways, parking areas, etc.,
- Exterior fences or repairs made to any such structure,
- Motion detector or alarm systems for security, fire, etc.,
- Fire sprinklers, extinguishers, hoses, etc.,
- Smoke, fire and carbon monoxide detectors,

- Interior/exterior non-portable oxygen sites,
- Replacement of toilets, septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring or fixtures when not affected by an adaptation, not part of the installation process or not one of the pieces of medical equipment being installed,
- Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.),
- Any service covered by the Medicaid State Plan, or
- Any equipment or supply covered by the Medicaid Durable Medical Equipment (DME) program.

Only those adaptations or improvements not available as a DME device may be authorized.

NOTE: Some lifts, filters, etc., may be covered as a DME item. The support coordinator must first explore the possibility of these items being covered through the DME program by assisting the recipient in making a prior authorization (PA) request with a DME provider.

Service Limitations

Services must be pre-approved by the OAAS regional office or its designee and be prior authorized.

It is strictly prohibited for the provider to charge the recipient an amount in excess of the prior approved amount for completion of the job.

Reimbursement

Reimbursement for environmental accessibility adaptation services shall be billed for the amount approved. The assessor/inspector/approver must approve the completion of the modification prior to billing.

Personal Assistance Services

Personal assistance services (PAS) include assistance and/or supervision necessary for the recipient with functional impairments to remain safely in the community. PAS includes the following services and supports based on the approved POC:

- Supervision or assistance in performing activities of daily living (ADLs),

- Supervision or assistance in performing instrumental activities of daily living (IADLs),
- Protective supervision solely to assure the health and welfare of the recipient,
- Supervision or assistance with health related tasks,
- Supervision or assistance while escorting/accompanying the recipient outside the home to perform tasks, including IADLs, health maintenance or other needs as identified in the Plan of Care and to provide the same supervision or assistance as would be provided in the home, and
- Extension of therapy services, defined as:
    - Assistance in reinforcing instruction and aids in the rehabilitative process by an attendant who has been instructed by a licensed therapist on the proper way to assist the recipient in follow-up therapy sessions.
    - Performance of basic interventions by an attendant who has been instructed by a registered nurse on how to increase and optimize functional abilities in performing ADLs such as range of motion exercise.

Transportation is not a required component of PAS although providers may choose to furnish transportation for recipients during the course of providing PAS. If transportation is furnished, the provider must accept all liability for their employee transporting a recipient. It is the responsibility of the provider to ensure that the employee has a current, valid driver's license and automobile liability insurance.

PAS is provided in the recipient's home or can be provided in another location outside of the recipient's home if the provision of these services allows the individual to participate in normal life activities pertaining to the ADLs and IADLs cited in the Plan of Care. IADLs may not be performed in the recipient's home when the recipient is absent from the home. There shall be no duplication of services. PAS may not be provided while the recipient is attending or admitted to a program or setting which provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided.

The provision of PAS services outside of the participant's home does not include trips outside of the borders of the state without prior, written approval by OAAS or its designee, through the Plan of Care or otherwise.

The PAS allotment may be used flexibly in accordance with the recipient's preferences and

personal schedule and OAAS's documentation requirements when the following guidelines are met:

- The approved allocation must be used in accordance with the recipient's preferences within a single, specific prior authorization period.
- Unused portions of the prior authorized allocation may not be saved or borrowed from one prior authorized period to another.
- Total hours used may not exceed the prior authorized period amount.
- Variations from the approved Plan of Care in accordance with the recipient's preference must be documented by the direct service worker on the designated service log. (See Section 7.8 – Record Keeping)
- The **need** for paid support/assistance with particular tasks/services, without assignment of specific time per task, must be documented in the approved Plan of Care.

Supervision or Assistance with Activities of Daily Living

Recipients may receive supervision or assistance in performing the following ADLs for their continued well-being and health:

- Eating
    - Verbally reminding the recipient to eat
    - Cutting food into bite-size pieces
    - Assisting the recipient with feeding and/or
    - Assisting the recipient with adaptive feeding devices (not to include tube feeding unless the direct service worker has received the required training pursuant to R.S. 37:1031-1034)
- Bathing
    - Verbally reminding the recipient to bathe
    - Preparing the recipient's bath
    - Assisting the recipient with dressing and undressing
    - Assisting the recipient with prosthetic devices

- Dressing
    - Verbally reminding the recipient to dress
    - Assisting the recipient with dressing and undressing
    - Assisting the recipient with prosthetic devices
- Grooming
    - Verbally reminding the recipient to groom
    - Assisting the recipient with shaving, applying make-up, body lotion or cream
    - Brushing or combing the recipient's hair
    - Brushing the recipient's teeth
    - Other grooming activities
- Transferring
    - Assisting the recipient with moving body weight from one surface to another, such as moving from a bed to a chair or
    - Assisting the recipient with moving from a wheelchair to a standing position
- Ambulation
    - Assisting the recipient with walking or
    - Assisting the recipient with wheelchair use
- Toileting
    - Verbally reminding the recipient to toilet
    - Assisting the recipient with bladder and/or bowel requirements, including bedpan routines
    - Draining/emptying a catheter or ostomy bag is allowed, but this is not to include removing or changing bags or tubing, inserting, removing and sterilizing irrigation of catheters

Supervision or Assistance with Instrumental Activities of Daily Living

Recipients may receive supervision or assistance in performing routine household tasks that may not require performance on a daily basis, but are essential for sustaining their health and welfare. **The purpose of providing assistance or support with these tasks is to meet the needs of the**

recipient, not the housekeeping needs of the recipient's household. Assistance or support with IADLs includes the following:

- Light housekeeping
    - Vacuuming and mopping floors
    - Cleaning the bathroom and kitchen
    - Making the recipient's bed
    - Ensuring pathways are free from obstructions
- Food preparation and food storage as required specifically for the recipient
- Shopping (with or without the recipient) for items specifically for the recipient such as
    - Groceries
    - Personal hygiene items
    - Medications
    - Other personal items
- Laundry of the recipient's clothing and bedding
- Medication reminders with self-administered prescription and non-prescription medication that is limited to
    - Verbal reminders
    - Assistance with opening the bottle or bubble pack
    - Reading the directions from the label
    - Checking the dosage according to the label directions
    - Assistance with ordering medication from the drug store

    NOTE: Assistance does NOT include taking medication from the bottle to set up pill organizers, administering medications and applying dressing that involves prescription medication and aseptic techniques of skin problems, unless the direct service worker has received the required training pursuant to R.S. 37:1031-1034.
- Assistance with scheduling (making contacts and coordinating) medical appointments including, but not limited to appointments with
    - Physicians
    - Physical therapists

- Occupational therapists
- Speech therapists

- Assistance in arranging medical transportation depending on the needs and preferences of the recipient with

  - Medicaid emergency medical transportation
  - Medicaid non-emergency medical transportation
  - Public transportation
  - Private transportation

- Accompany the recipient to medical appointments

Protective Supervision

Protective supervision may be provided to assure the health, welfare and maintenance of a recipient who has cognitive or memory impairment or who has physical weakness as defined by the OAAS comprehensive assessment.

Supervision or Assistance with Health-Related Tasks

Supervision or assistance with health-related tasks, as specified in the Plan of Care, may be provided to recipients (any health related procedures governed under the Nurse Practice Act where the direct service worker has received the required training pursuant to R.S. 37:1031-1034). Supervision or assistance includes, but is not limited to, medication administration.

Supervision or Assistance while Escorting/Accompanying with Community Tasks

Supervision or assistance may be provided to recipients while escorting or accompanying the recipient outside of the home to perform tasks, including IADLs, health maintenance or other needs as identified in the Plan of Care, and to provide the same supervision or assistance as would be rendered in the home.

Extension of Therapy Services

Licensed therapists may choose to instruct attendants on the proper way to assist the recipient in follow-up therapy sessions to reinforce and aid the recipient in the rehabilitative process. The attendant may also be instructed by a registered nurse to perform basic interventions with the recipient that would increase and optimize functional abilities for maximum independence in performing ADLs such as range of motion exercise. Instruction provided by licensed therapists and registered nurses must be documented.

Shared PAS

PAS may be provided by one worker for up to three Community Choices Waiver recipients who live together and have a common direct service provider (DSP).

Waiver recipients may share PAS staff when agreed to by the recipients and the health and welfare of each can be reasonably assured. Shared PAS is to be identified in the approved Plan of Care of each recipient. Reimbursement rates are adjusted accordingly. Due to the requirements of privacy and confidentiality, recipients who choose to share these services must agree to sign a confidentiality consent form to facilitate the coordination of services.

A.M./ P.M. Delivery Method

PAS may be provided through an "a.m./p.m." delivery method. This delivery method provides PAS to the recipient at the beginning and/or end of the day. Recipients utilizing this optional delivery method receive at least one hour, but no more than two hours, of service during each session. If both the "a.m." and the "p.m." sessions are provided, there must be at least a four hour break between the two sessions. On any calendar day that a recipient utilizes this delivery method, he/she may not receive more than four hours of PAS on that calendar day. The "a.m./p.m." delivery method is not to be shared.

It is permissible to receive only the "a.m." or "p.m." portion of PAS within a calendar day.

PAS providers must be able to provide both regular and "a.m." and "p.m." PAS and cannot refuse to accept a Community Choices Waiver recipient solely due to the type of PAS delivery method that is listed on the POC.

Standards

Providers must be licensed by the Health Standards Section (HSS) as a Personal Care Attendant or a Home Health provider, comply with DHH rules and regulations, and be listed as a provider of choice on the FOC form before being approved to provide services.

A home health agency's direct service worker (DSW) who renders PAS must be a qualified home health aide as specified in Louisiana's *Minimum Licensing Standards for Home Health Agencies.*

PAS providers must develop an individualized back-up staffing plan and agreement. This plan is used when the recipient's assigned PAS worker is unable to provide support due to unplanned circumstances including but not limited to emergencies which arise during a shift. The individualized plan and agreement shall be developed and maintained in accordance with OAAS

policy. If the provider cannot meet the recipient's needs, the provider must submit "good cause" reasons to the OAAS regional office.

PAS providers shall ensure timely completion of the "OAAS Emergency Plan" for each waiver recipient they serve in accordance with OAAS Policy. (See Appendix B for information on accessing this form)

Service Exclusions

PAS providers may not bill for this service until after the individual has been approved for the Community Choices Waiver.

"A.m." and/or "p.m." PAS may not be provided on the same calendar day as other PAS delivery methods.

PAS may not be billed at the same time of service as Adult Day Health Care (ADHC) and Caregiver Temporary Support services.

The following individuals are prohibited from being reimbursed for providing services to a recipient:

- The recipient's spouse,
- The recipient's curator,
- The recipient's tutor,
- The recipient's legal guardian,
- The recipient's responsible representative, or
- The person to whom the recipient has given representative and mandate authority (also known as power of attorney).

Recipients are not permitted to receive PAS while living in the home or property owned, operated, or controlled by a provider of services who is not related by blood or marriage to the recipient.

Service Limitations

Services must be approved by the OAAS regional office or its designee and be prior authorized. In order to bill for these services, the DSW must be with the recipient, be awake, alert and available to respond to the recipient's immediate needs.

Assistance or support with ADL tasks shall not include teaching a family member or friend how to care for a recipient who requires assistance with any ADL.

The provision of PAS services outside of the recipient's home does not include trips outside of the borders of the state without prior written approval of OAAS or its designee, through the Plan of Care or otherwise.

PAS cannot be provided or billed at the same hours on the same day as shared PAS.

Recipients cannot receive PAS from the "a.m./p.m." delivery method **on the same calendar day** as other PAS service delivery methods.

Recipients utilizing the "a.m./p.m." delivery method must be provided with at least one hour, but no more than two hours, of service during each session. If both the "a.m." and the "p.m." sessions are provided, there must be at least a four hour break between the two sessions.

Recipients receiving shared PAS must each be:

- Approved to receive Community Choices Waiver services,
- Share the same residence, and
- Have a common DSP.

Shared PAS cannot be billed on behalf of a recipient who was not present to receive the service.

"A.m./p.m." PAS cannot be shared.

A home health agency is limited to providing services within a 50-mile radius of its parent agency. This limit may be waived by the appropriate DHH authority on a case-by-case basis as needed.

Reimbursement

Payment shall not be authorized until the OAAS regional office or its designee gives final Plan of Care approval. When all requirements are met, the support coordinator provides a copy of the approved Plan of Care to the recipient and DSP. The DSP is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

Prior authorization for direct service provider agencies is based on a weekly cap and is released on a daily basis. Unused portions of the prior authorized weekly allotment may not be saved or borrowed from one week for use in another week.

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 Plan of Care. The recipient must be present to receive the service in order for the provider to bill for the service.

Shared and unshared PAS must be billed in 15 minute increments.

"A.m./p.m." PAS must be billed per visit.

Adult Day Health Care Services

Adult Day Health Care (ADHC) services provide a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. ADHC services are furnished as specified in the Plan of Care at an ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the recipient.

ADHC services include:

- Transportation between the recipient's place of residence and the ADHC in accordance with licensing standards,
- Meals to include a minimum of two snacks and a hot nutritious lunch,
- Assistance with activities of daily living,
- Health and nutrition counseling,
- Individualized exercise program,
- Individualized, goal-directed recreation programs,

- Health education classes, and
- Individualized health/nursing services that include the following:
    - Monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly,
    - Administering medications and treatments in accordance with physicians' orders, and
    - Monitoring individualized plans for self-administration of medications.

    NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

Transportation

The cost of transportation is included in the rate paid to providers of ADHC services. The recipient and his/her family may choose to transport the recipient to the ADHC center. Transportation provided by the recipient's family is not a reimbursable service.

Transportation may be provided to and from medical and social activities when the recipient is accompanied by ADHC center staff.

Centers are expected to provide transportation to any recipient within their licensed region, but it is permissible for recipients to attend an ADHC center outside of their region. Regardless of the recipient's region of origin, no recipient may be in transported for more than one hour on any single trip.

Standards

Providers must be licensed by the HSS as an Adult Day Health Care provider, enrolled in Medicaid as an ADHC provider , comply with DHH rules and regulations, and must be listed as a provider of choice on the FOC form prior to providing ADHC services.

Service Exclusions

ADHC providers shall not bill for this service until after the individual has been approved for the Community Choices Waiver.

ADHC service may not be billed at the same time of service as PAS and caregiver temporary support service.

Service Limitations

These services must be provided in the ADHC facility that has been selected by the recipient.

ADHC services may be provided no more than 10 hours per day and no more than 50 hours per week.

Reimbursement

Payment will not be authorized until the OAAS regional office or its designee gives final Plan of Care approval.

OAAS regional office, or its designee, reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved Plan of Care to the recipient and ADHC provider. The ADHC provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

ADHC services must be billed in 15 minute units.

Caregiver Temporary Support Service

Caregiver temporary support service is furnished on a short-term basis because of the absence or need for relief of caregivers during the time they would normally provide unpaid care for the recipient. The purpose of caregiver temporary support is to provide relief to unpaid caregivers to maintain the recipient's informal support system. Federal financial participation is not claimed for the cost of room and board except when provided as part of caregiver temporary support service furnished in a facility approved by the state that is not a private residence.

Caregiver temporary support service is provided in the following locations:

- The recipient's home or place of residence,
- Nursing facilities,
- Assisted living facilities,
- Respite centers, or
- ADHC centers.

Caregiver temporary support service may be provided in the recipient's home by a Medicaid enrolled PCA or home health agency.

Caregiver temporary support service that is provided by nursing facilities, assisted living and respite centers must include an overnight stay.

Caregiver temporary support service that is provided by an ADHC center may not be provided for more than 10 hours per day.

Standards

Providers must comply with DHH rules and regulations and be listed as a provider of choice on the FOC form as a caregiver temporary support provider prior to providing service.

Providers meet the following licensure requirements and Medicaid enrollment requirements:

Provider	Licensure and Enrollment Requirements
Respite Center	Respite Center license and Enroll as a Respite Center provider with applicable sub-specialty
Assisted Living Center	Assisted Living Center license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
Adult Day Health Care	Adult Day Health Care license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
Nursing Facility	Nursing Facility license and Enroll as a Caregiver Temporary Support provider with applicable sub-specialty
PCA Agency	Personal Care Attendant license and Enroll as a Waiver Personal Care Attendant with applicable sub-specialty
Home Health Agency	Home Health Agency license and Enroll as a Home Health Agency with applicable sub-specialty

Service Exclusions

Caregiver temporary support service may not be delivered/billed at the same time as PAS or ADHC.

Service Limitations

These services must be prior approved by the OAAS regional office or its designee.

Caregiver temporary support service may be utilized for no more than 30 calendar days or 29 overnight stays per Plan of Care year for no more than 14 consecutive days or 13 consecutive overnight stays.

These service limits may be increased based on documented need.

Reimbursement

Payment will not be authorized until the OAAS regional office or its designee gives final Plan of Care Approval.

For providers of overnight center-based services, the prior authorization 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.

Caregiver temporary support service must be billed as follows:

Type of Provider	Billing Units
Waiver PCA Home Health ADHC	15 minute unit of service
Respite Care Centers Assisted Living Centers Nursing Facilities	Daily unit of service

Assistive Devices and Medical Supplies

Assistive devices and medical supplies are specialized medical equipment and supplies which include devices, controls, appliances, or nutritional supplements specified in the Plan of Care that enable recipients to increase or maintain their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live or provide emergency response.

Assistive devices and medical supplies also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of assistive devices, and durable and non-durable medical equipment. This service includes a personal emergency response system (PERS) and other in-home monitoring and medication management devices and technology.

This service may also be used for routine maintenance or repair of specialized equipment. Batteries, extended warranties, and service contracts that are cost effective may be reimbursed. This includes medical equipment and necessary medical supplies not available under the state plan that addresses recipient functional limitations addressed in the Plan of Care.

Where applicable, recipients must use Medicaid state plan services, Medicare, or other available payers first. The recipient's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

Personal Emergency Response System (PERS)

PERS is an electronic device which enables the recipient to secure help in an emergency. PERS services are limited to specific recipients.

The unit is connected to the telephone line and is programmed to send an electronic message to a community-based 24-hour emergency response center when a "help" button is activated. This unit may either be worn by the recipient or installed in his/her home.

PERS services are limited to recipients who live alone, or are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive, routine supervision. It is only appropriate for recipients who are cognitively and/or physically able to operate the system. PERS is a measure to promote the health and welfare of the recipient.

The PERS unit shall be rented from the PERS provider. Billing for this service involves an installation fee and a monthly maintenance fee which includes the cost of maintenance and training the recipient how to use the equipment. The PERS unit must be installed in the recipient's residence. Reimbursement of these services requires PA.

The PERS must be checked monthly by the provider to ensure it is functioning properly. The PERS battery/unit must be checked once every quarter by the support coordinator during the home visit.

TeleCare Activity and Sensor Monitoring

This service is a computerized system that monitors the recipient's in-home movement and activity for health, welfare and safety purposes. The system is individually set based on the recipient's typical in-home movements and activities. The provider agency is responsible for monitoring electronically-generated information, for responding as needed, and for equipment maintenance. At a minimum, the system shall:

- Monitor the home's points of egress and entrance,
- Detect falls,
- Detect movement or the lack of movement,
- Detect whether doors are opened or closed, and
- Provide a push-button emergency alert system.

NOTE: Some systems may also monitor the home's temperature.

Standards

Providers of assistive devices and certain medical equipment and supplies must be a licensed home health agency, comply with DHH rules and regulations, be enrolled in Medicaid to provide these services and be listed as a provider of choice on the FOC form.

PERS and certain durable medical equipment providers must comply with OAAS's standards for participation, be enrolled as the applicable Medicaid provider type and be listed as a provider of choice on the FOC form.

The PERS provider must install and support PERS equipment in compliance with all applicable federal, state, parish and local laws and regulations, as well as meet manufacturer's specifications, response requirements, maintenance records, and recipient education.

PERS devices must meet Federal Communications Commission standards or Underwriter's Laboratory standards or equivalent standards.

Service Exclusions

No experimental items are allowed.

Service Limitations

Services must be pre-approved by the OAAS regional office or its designee and be prior authorized.

Services must be based on a verified need of the recipient and the service must have a direct or remedial benefit with specific goals and outcomes.

The benefit must be determined by an independent assessment on any item that costs over $500 and on all communication devices, mobility devices, and environmental controls.

Independent assessments are done by the appropriate professional, e.g., an occupational therapist, physical therapist, and/or speech/language pathologist, who has no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

All items must reduce reliance on other Medicaid state plan or waiver services.

All items must meet applicable standards of manufacture, design, and installation.

The items must be on the Plan of Care developed by the support coordinator and are subject to approval by OAAS regional office or its designee. No experimental items shall be authorized.

A recipient will not be able to simultaneously receive TeleCare Activity and Sensor Monitoring services and traditional PERS services.

NOTE: Where applicable, recipients must use Medicaid State Plan, Medicare, or other available payers first. The recipient's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

Reimbursement

Assistive devices and medical supplies providers may not bill for this service until after the recipient has been approved for the Community Choices Waiver.

Payment shall not be authorized until the OAAS regional office or its designee gives final Plan of Care approval.

Billing for PERS or TeleCare Activity and Sensor Monitoring 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 service or TeleCare Activity and Sensor Monitoring service moves to a different location or changes providers, reimbursement for a second installment is permissible.

Home Delivered Meals

The purpose of home delivered meals is to assist recipients in meeting their nutritional needs in support of the maintenance of self-sufficiency and enhancing their quality of life.

Home delivered meals includes up to two nutritionally balanced meals per day to be delivered to the home of a recipient who is:

- Unable to leave the home without assistance,
- Unable to prepare his/her own meals, and/or
- Has no responsible caregiver in the home.

The home delivered meal is to provide the recipient a minimum of one-third of the current recommended dietary allowance (RDA) as adopted by the United States Department of Agriculture (USDA). The provision of home delivered meals does not provide a full nutritional regimen.

Standards

All in-state providers must meet all Louisiana Office of Public Health certification, permit and inspection requirements for retail food preparation, processing, packaging, storage and distribution.

All out-of-state providers must meet retail food preparation, processing, packaging, storage and distribution requirements of the USDA and the state of operation.

All providers must be enrolled in Medicaid and comply with DHH rules and regulations.

Service Limitations

Meals are limited to two per day. It is permissible for recipients to have some meals delivered daily and others delivered in bulk by different providers as long as the maximum of two meals per day is not exceeded.

Reimbursement

Payment shall not be authorized until the OAAS regional office or its designee gives final Plan of Care approval.

The data management contractor will issue annual PAs for a maximum of two meals per day and for a maximum of 14 meals per week. One unit of service equals one meal.

Providers will be allowed to span date bill for up to two weeks supply of meals.

Nursing

Nursing services are services that are medically necessary and may be provided efficiently and effectively by a nurse practitioner, registered nurse (RN), or a licensed practical nurse (LPN) working under the supervision of an RN. Nursing services must be provided within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may include periodic assessment of the recipient's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers.

Nursing services may also include regular, ongoing monitoring of a recipient's fragile or complex medical condition as well as the monitoring of a recipient with a history of noncompliance with medication or other medical treatment needs.

Nursing services may also be used to assess a recipient's need for assistive devices or home modifications, training the recipient and family members in the use of the purchased devices, and training of DSWs in tasks necessary to carry out the Plan of Care.

All services must be based on a verified need of the recipient and must have a direct or remedial benefit to the recipient with specific goals and outcomes.

Standards

Providers must be enrolled in Medicaid as a nursing provider, comply with DHH rules and regulations, and must be listed as a provider of choice on the FOC form.

Nursing services provided must be within the scope of the Louisiana Statutes governing the practice of nursing.

Nursing services may be provided by a nurse practitioner, a RN or LPN employed by a home health agency.

Service Exclusions

Nursing providers shall not bill for this service until after the recipient has been approved for the Community Choices Waiver.

Nursing services shall not be provided when the recipient is an inpatient at a hospital.

Service Limitations

Services must be approved by the OAAS regional office or its designee and be prior authorized.

Services must be based on a verified need of the recipient.

Services must have a direct or remedial benefit to the recipient with specific goals and outcomes.

Providers are not required to have a doctor's order for an assessment and treatment/service before this service is reimbursed by the Community Choices Waiver. Providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

NOTE: Where applicable, recipients must use Medicare or other available payers first. The recipient's preference for a certain staff or agencies is not grounds for declining another payer in order to access waiver services.

Reimbursement

Payment shall not be authorized until the OAAS regional office or its designee gives final Plan of Care approval.

Data management contractor will issue PAs for no more than 6 months.

Skilled Maintenance Therapy (Physical, Occupational, Respiratory and Speech/Language)

Skilled maintenance therapy includes physical therapy, occupational therapy, respiratory therapy and/or speech and language therapy that may be received by Community Choices Waiver recipients in their home.

Therapy services provided to recipients under the waiver are not necessarily tied to an episode of illness or injury and instead focus primarily on the person's functional need for maintenance of or reducing the decline in the recipient's ability to carry out activities of daily living.

Skilled maintenance therapies may also be used to assess a recipient's need for assistive devices or home modifications, training the recipient and family members in the use of the purchased devices, performance of in-home fall prevention assessments, and participation on the Plan of Care planning team. Services may be provided in the recipient's home or in a variety of locations as approved by the Plan of Care planning team.

Physical Therapy

Physical therapy services promote the maintenance of or reduction in the loss of gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. Specific services may include:

- Professional assessments,
- Evaluations and monitoring for therapeutic purposes,
- Physical therapy treatments and interventions,
- Training regarding physical therapy activities,
- Use of equipment and technologies,
- Designing, modifying or monitoring the use of related environmental modifications,
- Designing, modifying, and monitoring the use of related activities supportive to the Plan of Care goals and objectives, or
- Consulting or collaborating with other service providers or family members, as specified in the Plan of Care.

Occupational Therapy

Occupational therapy services promote the maintenance of, or reduction in, the loss of fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology.

Specific services may include:

- Teaching of daily living skills,
- Development of perceptual motor skills and sensory integrative functioning,
- Design, fabrication, or modification of assistive technology or adaptive devices,
- Provision of assistive technology services,

- Design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment,
- Use of specifically designed crafts and exercise to enhance function,
- Training regarding occupational therapy activities, and
- Consulting or collaborating with other service providers or family members as specified in the Plan of Care.

Speech Language Therapy

Speech language therapy services preserve abilities for independent function in communication, facilitate oral motor and swallowing function, facilitate use of assistive technology, and/or prevent progressive disabilities.

Specific services may include:

- Identification of communicative or oropharyngeal disorders,
- Prevention of communicative or oropharyngeal disorders,
- Development of eating or swallowing plans and monitoring their effectiveness,
- Use of specifically designed equipment, tools, and exercises to enhance function,
- Design, fabrication, or modification of assistive technology or adaptive devices,
- Provision of assistive technology services,
- Adaptation of the recipient's environment to meet his/her needs,
- Training regarding speech language therapy activities, and
- Consulting or collaborating with other service providers or family members as specified in the Plan of Care.

Standards

Skilled Maintenance Therapy services may be provided by home health agencies that employ licensed therapists, comply with DHH rules and regulations and be listed as a provider of choice on the FOC form.

Service Exclusions

Providers may not bill for services until after the individual has been approved for the Community Choices Waiver program.

Skilled maintenance therapies shall not be provided when the recipient is an inpatient at a hospital.

Service Limitations

Services must be based on a verified need of the recipient.

The service must have a direct or remedial benefit to the recipient with specific goals and outcomes.

Providers are not required to have a doctor's order for assessments or treatment/services before this service is reimbursed through the Community Choices Waiver Program; however, providers may be required to have a doctor's order for assessments and treatment/services before this service is reimbursed by other payers.

NOTE: Where applicable, the recipient must use Medicare, Medicaid state plan, or other available payers first. The recipient's preference for a certain therapist or agency is not grounds for declining another payer in order to access waiver services.

Reimbursement

Payment shall not be authorized until the OAAS regional office or its designee gives final Plan of Care approval.

A prior authorization period will not exceed 6 months.

Hospice and Waiver Services

Recipients who receive waiver services may also be eligible for Medicaid hospice services.

Waiver recipients who elect the hospice benefit do not have to dis-enroll from the waiver program, but they must be under the direct care of the Medicaid hospice provider for those services both programs have in common. Waiver recipients who elect the hospice benefit can still receive waiver services as long as they **are not related to the terminal hospice condition and are not duplicative of hospice care.**

Waiver Services Payable While in a Nursing Facility

Certain Community Choices Waiver services are payable when transitioning from a nursing facility or for a recipient during a temporary stay in a nursing facility. (See Appendix F for a complete list of the Community Choices Waiver services)