COVERED SERVICES

This section provides information about the services that are covered in the Elderly and Disabled Adult Waiver program. For the purpose of this policy, whenever reference is made to "individuals", this includes providing assistance to the individual's personal representative(s), legal guardian(s) and/or family member(s), when applicable and appropriate as they assist the recipient to obtain these services.

Support Coordination

Support coordination, also referred to as case management, is a service designed to assist recipients in gaining access to necessary waiver and State Plan services, as well as medical, social, educational and other services, regardless of the funding source for these services. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the recipient's approved Plan of Care.

Standards

Providers must be licensed by the Medicaid Health Standard Section (HSS) as a case management provider, be enrolled in Medicaid as a provider of this service and sign a performance agreement with the Department of Health and Hospitals (DHH), Office of Aging and Adult Services (OAAS). Refer to the Case Management Services manual chapter for more detailed information about this service.

Transition Intensive Support Coordination

Transition intensive support coordination (TISC) assists individuals currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and Medicaid State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source.

Standards

Providers must be licensed by the Medicaid HSS as a case management provider, be enrolled in Medicaid as a provider of this service, sign a performance agreement with the DHH OAAS and be listed on the Freedom of Choice Form (FOC). Refer to the Case Management Services manual chapter for more detailed information about this service.

Service Exclusions

Support coordination agencies are not allowed to bill for this service until after the individual has

been approved for the EDA Waiver.

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

Service Limitations

Support coordination agencies may be reimbursed up to four months prior to the date the individual transitions from the nursing facility. 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. Support coordination agencies 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 four months prior to the date of transition. Payment will not be authorized until the OAAS regional office gives final Plan of Care approval after receipt of the 18-W form from the local Medicaid office. The vendor payment date is the date of the actual move from the nursing facility.

NOTE: The vendor payment date cannot be prior to the date that the individual is discharged from the nursing facility.

Payment for claims for this service requires an override from the Medicaid Waiver Assistance and Compliance (WAC) section. The support coordinator must submit a completed paper claim (CMS 1500), a "Request for Payment/Override Form," the Plan of Care approval page and budget page and all required documentation (e.g. progress notes, etc.) to the OAAS regional office. (See Appendix B for a copy of the Request for Payment/Override Form)

Once the override request has been approved, the support coordination agency will be notified by the OAAS regional office to proceed with billing.

Transition Services

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

Transition Services offer assistance with time limited, non-recurring set-up expenses for individuals who have been offered and approved for an EDA Waiver opportunity and are transitioning from a nursing facility to their own living arrangement. Allowable expenses are those necessary to enable the individual to establish a basic household. These services must be

identified in the individual's approved Plan of Care.

When the individual requires services that exceed the one-time maximum allowed, the support coordinator identifies and refers the individual and/or responsible representative to other community resources.

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 housing start-up fees and 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, and dishcloths, towels, 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.

Standards

Providers must be licensed by the HSS as a case management provider, enrolled in Medicaid as a provider of these services, sign a performance agreement with the DHH OAAS, and be listed on the FOC form.

Refer to the Case Management Services manual chapter for more detailed information about this service.

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 diversionary/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.

Service Limitations

There is a $1,500 one-time maximum limit per individual. Services must be prior approved by the OAAS regional office and require prior authorization.

These services are available to individuals who are transitioning from a nursing facility to their own private residence where the individual is directly responsible for his/her own living expenses. When the individual 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 individual.

The purchaser for these items may be the individual, 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 gives final Plan of Care approval upon receipt of the 18-W.

When the OAAS regional office issues final approval, the data management contractor is notified to set up a transition service expense record in the database for the individual and to release the PA. The support coordination agency is notified of the release of the PA 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 that actual purchaser within ten calendar days of receipt of reimbursement by the support coordination agency.

The OAAS regional office 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.

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 EDA Waiver services and/or does not transition, but transition service items were purchased, the OAAS regional office should notify the OAAS state office to allow for possible reimbursement.

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

Environmental Accessibility Adaptations

Environmental accessibility adaptations are those necessary physical adaptations made to the home to ensure 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.

These services must also be provided in accordance with the recipient's approved Plan of Care, the approved "OAAS Environmental Accessibility Adaptation Job Completion Form" and Medicaid regulations. (See Appendix B for a copy of this form)

Adaptations may be applied to rental or leased property with written approval of the landlord and approval of the OAAS regional office.

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.

Environmental accessibility adaptations include the following:

- Ramps
    - portable
    - fixed
- Lifts
    - porch
    - stair
    - hydraulic
    - manual
    - other 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. The support coordinator 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, or engineers). Providers must enroll as a Medicaid Environmental Modifications provider, be listed on the FOC form and file claims in accordance with established Medicaid guidelines.

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.

Service Exclusions

Providers may not bill for this service until after the individual has been approved for the EDA waiver program and all required documentation is completed by both the recipient and the OAAS regional office.

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 Medicaid State Plan services, 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

There is a $3,000 maximum lifetime limit per recipient. Services must be pre-approved by the OAAS regional office and be prior authorized. Expenditures are cumulative and claims that exceed the maximum lifetime limit will be denied. Should the recipient require services that exceed the lifetime limit, the support coordinator will refer the recipient to other community resources. 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 this service requires prior and final approval by the OAAS regional office. Payment will not be authorized until verification has been received that the job has been completed in accordance with the prior approved agreement.

Personal Emergency Response Systems (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.

Standards

A PERS vendor must be enrolled in Medicaid to provide this service and be listed on the FOC form. The 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.

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

Service Limitations

Services must be approved by the OAAS regional office and be prior authorized. Billing for this service involves an installation fee and a monthly maintenance fee. Only one claim for each month is allowed. Claims may be span dated (or not) at the discretion of the provider. Partial months shall not be billed.

If a recipient moves to a different location or changes providers, reimbursement for a second installment is permissible.

Reimbursement

PERS providers may not bill for this service until after the recipient has been approved for the EDA Waiver.

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:

- Supervision or assistance in performing activities of daily living (ADLs),
- Supervision or assistance in performing instrumental activities of daily living (IADLs),
- Protective supervision,
- Supervision or assistance with health related tasks,
- Escort assistance with community tasks, and

- Extension of therapy services.

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 individual'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 where such assistance is provided.

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

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 with a special billing code and applicable rate for each recipient. 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.

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)
- 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/injections and applying dressing that involves prescription medication and aseptic techniques of skin problems.
- 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 may be provided to recipients who have physician delegated non-complex medical tasks. Assistance must be provided in accordance with established physician delegation guidelines and the Nurse Practice Act. Supervision or assistance includes, but is not limited to, medication administration. (See Appendix B for a copy of the Physician Delegation for Medication Administration and Medical Treatments form)

Escort Assistance with Community Tasks

Supervision or assistance may be provided to recipients when escorting or accompanying the recipient outside of the home to perform IADLs, health maintenance or other needs as identified in the Plan of Care.

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.

Standards

Providers must be licensed by the HSS as a Personal Care Attendant provider, enrolled in Medicaid as a DSP and be listed on the FOC form before being approved to provide services.

Service Exclusions

DSPs may not bill for this service until after the individual has been approved for the EDA Waiver.

Service Limitations

Services must be approved by the OAAS regional office and be prior authorized. In order to bill for these services, the DSP staff 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.

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

For shared PAS, the recipients must each be:

- Enrolled in the EDA Waiver program, and
- Share the same residence, DSP and support coordination agency.

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

PAS must be billed in 15 minute increments.

These services must be provided in the State of Louisiana.

Reimbursement

Payment shall not be authorized until the OAAS regional office 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.

Adult Day Health Care Services

Adult Day Health Care (ADHC) services are a planned, diverse daily program of individual services and group activities structured to enhance the recipient's physical functioning and to provide mental stimulation. Services are furnished for five or more hours per day (exclusive of transportation time to and from the ADHC facility) on a regularly scheduled basis for one or more days per week, or as specified in the waiver Plan of Care and ADHC Individualized Service Plan (ISP).

An ADHC facility shall, at a minimum, furnish the following services:

- Individualized training or assistance with the activities of daily living (toileting, grooming, eating, ambulation, etc.),
- Health and nutrition counseling,
- An individualized, daily exercise program,
- An individualized, goal directed recreation program,
- Daily health education,
- Medical care management,
- One nutritionally-balanced hot meal (lunch) and two snacks each day. If applicable, the meals/snacks shall meet the recipient's dietary needs, as ordered by his/her physician. Two hours are required between the snack and lunch, one hour for lunch, and two hours between lunch and the next snack totaling five hours. Liquids shall be available and easily accessible at all times.

  NOTE: A provider may offer breakfast be served in place of a mid-morning snack.

- Nursing services that include the following individualized health services:
  - 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,
  - Monitoring self-administration of medications while the recipient is at the

ADHC facility, and

- Serving as a liaison between the recipient and medical resources including the treating physician.

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

- Transportation from the recipient's place of residence to the ADHC facility. The cost of this 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 facility. Transportation provided by the recipient's family is not a reimbursable service, and

- Transportation to and from medical and social activities when the recipient is accompanied by ADHC facility staff.

NOTE: If transportation services that are prescribed in any recipient's approved ISP are not provided by the ADHC facility, the facility's reimbursement rate shall be reduced accordingly. It is allowable for an ADHC to refuse services to someone because the individual resides outside of the ADHC's established limited mileage radius for transportation to and from the center as long as this transportation policy is approved by DHH HSS.

Standards

Providers must be licensed by the HSS as an Adult Day Health Care provider, enrolled in Medicaid as an ADHC provider and must be listed 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 EDA Waiver.

ADHC providers will not be reimbursed for any recipient who has attended less than five hours per day.

It is permissible for a person to attend an ADHC facility outside of their region.

Service Limitations

These services must be provided in the chosen ADHC facility.

Reimbursement for these services requires PA.

Reimbursement

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

OAAS regional office 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.

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 disenroll 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.**

Refer to the Case Management Services manual chapter for more detailed information about the coordination of waiver and hospice services.