LOUISIANA DEPARTMENT OF HEALTH

PERSONAL CARE SERVICES

Chapter Thirty of the Medicaid Services Manual

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

State of Louisiana
Bureau of Health Services Financing

PERSONAL CARE SERVICES

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LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) OVERVIEW

Long Term-Personal Care Services (LT-PCS) is an optional home and community-based service (HCBS) under the Medicaid State Plan. This program is designed for Medicaid beneficiaries who require assistance with the activities of daily living (ADL) and are either in a nursing facility or at imminent risk of nursing facility placement.

The purpose of LT-PCS is to assist individuals with functional impairments with their ADL. Assistance with instrumental activities of daily living (IADL) may also be provided if necessary as indicated in the plan of care (POC). LT-PCS must be prior authorized and provided in accordance with an approved POC. In addition, the POC must consider the coordination of services including Medicaid services, community services and informal supports being provided to the beneficiary without any duplication of services. LT-PCS does not replace current support or other assistance and is meant to supplement other sources. Medicaid is the payer of last resort for any services rendered.

Each individual requesting LT-PCS will undergo a functional eligibility screening, known as the Level of Care Eligibility Tool (LOCET), to determine if the following criteria are met:

1. Nursing facility level of care (NFLOC); and

2. Nursing facility admission is imminent.

LT-PCS applicants who have been determined to meet the requirements listed above are assessed using a face-to-face interRAI assessment. This assessment is utilized to:

1. Verify eligibility qualifications;

2. Determine if program requirements are met;

3. Determine resource allocation; and

4. Identify the individual's need for support in performance of ADL and IADL.

The services offered under the LT-PCS program are provided by a Medicaid enrolled provider that has a valid HCBS license issued by the Louisiana Department of Health (LDH) Health Standards Section (HSS).

This provider manual chapter specifies the requirements for reimbursement for services provided through this program. This document is a combination of federal and state laws and LDH policy

which provides direction for provision of these services to eligible individuals in the state of Louisiana.

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

This manual chapter is intended to provide LT-PCS providers with the information necessary to fulfill their vendor contract with the state of Louisiana. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and department rules.

Refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf for general information concerning topics relative to Medicaid provider enrollment and administration.

The LDH Bureau of Health Services Financing (BHSF), Office of Aging and Adult Services (OAAS), and HSS are responsible for assuring oversight of the provision of services, licensure compliance, program monitoring, and overall compliance with the rules and regulations.

Services to be provided are specified in the POC which is written by the OAAS designee. The planning team is comprised of the beneficiary, the assessor, and in accordance with the beneficiary's preferences, members of the family/natural support system, appropriate professionals and others whom the beneficiary chooses. The POC contains all services and activities involving the beneficiary. Notification of approved services is forwarded to the provider by the LTC Access contractor. The data contractor issues prior authorization (PA) to the providers based on the approved POC.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) COVERED SERVICES

This section provides information about the services that are covered in the Long-Term Personal Care Services (LT-PCS) program. For the purpose of this policy, when reference is made to "individual" or "beneficiary", this includes the individual/beneficiary's responsible representative, legal guardian(s), and/or family member(s) as applicable, who are assisting that individual in obtaining services.

LT-PCS may be received through the Medicaid State Plan, in conjunction with the Adult Day Health Care (ADHC) Waiver or the Supports Waiver (SW).

Beneficiaries who are approved for LT-PCS cannot receive the following Office of Aging and Adult Services (OAAS) Home and Community-Based Services (HCBS) at the same time:

1. Community Choices Waiver (CCW); and/or

2. Program of All-Inclusive Care for the Elderly (PACE).

NOTE: For these ADHC Waiver beneficiaries, support coordinators work with beneficiaries to coordinate their waiver services and LT-PCS. For these SW beneficiaries, the support coordinators will coordinate LT-PCS in terms of their daily schedule; however, LT-PCS is accessed separately through the Medicaid State Plan.

Service Definitions

Activities of Daily Living (ADL) are personal functions or basic self-care tasks which are performed by an individual in a typical day. They include the following tasks:

1. Bathing, which includes the following:

    a. Verbal reminder to take a bath;

    b. Preparation of the bath;

    c. Assistance transferring in and out of the bath/shower; and/or

    d. Physical assistance with bathing and/or drying off.

2. Grooming, which includes the following:

a. Verbal reminder to do the task;

b. Assistance with shaving;

c. Application of make-up and/or body lotion or cream;

d. Brushing or combing hair;

e. Brushing teeth; and/or

f. Other grooming activities.

3. Dressing, which includes the following:

a. Verbal reminder to dress;

b. Physical assistance with putting on/taking off clothing; and/or

c. Assistance with prosthetic devices.

4. Ambulation, which includes the following:

a. Supervision or assistance with walking; and/or

b. Supervision or assistance with assistive devices. (e.g. wheelchair, walker, etc.).

5. Eating, which includes the following:

a. Verbal reminder to eat;

b. Cutting up food;

c. Assistance with feeding; and/or

d. Assistance with adaptive feeding devices.

6. Transferring, which includes the following:

a. Assistance with moving body weight from one surface to another; and/or

b. Assistance with moving from a wheel chair to a standing position.

NOTE: Assistance provided to get on/off commode is a subtask of toileting. Assistance getting into/out of tub or shower is a subtask of bathing.

7. Toileting, which includes the following:

a. Verbal reminder to toilet;

b. Assistance with bladder and/or bowel requirements, including bedpan routines and changing pads or adult briefs (if required); and/or

c. Assistance with getting on/off of the commode (toilet).

8. Bed mobility, which includes the following:

a. Assistance with repositioning while in bed;

b. Moving to and from a laying position; and/or

c. Turning in bed.

Instrumental activities of daily living (IADL) are routine tasks that are considered essential, but may not require performance on a daily basis. **The purpose of providing assistance or support with these tasks is to meet the needs of the beneficiary, NOT the needs of the beneficiary's household.**

IADL tasks include the following:

1. Laundry of the beneficiary's clothing and bedding.

2. Meal preparation and storage for the beneficiary;

3. Shopping, with or without the beneficiary, for items specifically for the beneficiary, such as:

a. Groceries;

b. Personal hygiene items;

c. Medications; and/or

d. Other personal items.

4. Light housekeeping, such as:

a. Vacuuming;

b. Mopping floors;

c. Cleaning bathroom and kitchen;

d. Making the beneficiary's bed; and/or

e. Making sure that pathways are free from obstructions.

5. Assistance with scheduling (making contacts and coordinating) medical appointments including, but not limited to:

a. Physicians;

b. Physical Therapists;

c. Occupational Therapists; and/or

d. Speech Therapists.

6. Accompanying the beneficiary to medical appointments and providing assistance throughout the appointments;

7. Assistance in arranging medical transportation depending on the needs and preferences of the beneficiary with the following:

a. Medicaid emergency medical transportation;

b. Medicaid non-emergency medical transportation;

c. Public transportation; and/or

d. Private transportation.

8. Medication reminders with self-administered prescription and non-prescription medication that is limited to the following:

   a. Verbal reminders;

   b. Assistance with opening the bottle or bubble pack;

   c. Reading the directions from the label;

   d. Checking the dosage according to the label directions; and/or

   e. Assistance with ordering medication from the drug store.

   NOTE: The Direct Service Worker (DSW) is **NOT** allowed to give medication to the beneficiary. This includes taking medicine out of a bottle to set up pill organizers.

9. Medically non-complex tasks where the DSW has received the proper training pursuant to Revised Statutes 37:1031-1034. For a list of non-complex tasks that are delegable, see Appendix A, *Health Standards Section DSW Guidelines.*

NOTE: Emergency and non-emergency medical transportation is a covered Medicaid service and is available to all beneficiaries. Non-medical transportation is **NOT** a required component of LT-PCS. However, providers **MAY CHOOSE** to furnish transportation for beneficiaries during the course of providing LT-PCS. If transportation is furnished, the provider must accept all liability for their employee transporting a beneficiary. It is the responsibility of the provider to ensure that the DSW has a current, valid driver's license and automobile liability insurance. Refer to HCBS Provider Licensing Standards for complete details.

Service Limitations

Beneficiaries are limited to the weekly approved amount of LT-PCS hours indicated in the plan of care (POC) and based on the results of the assessment. The maximum amount of LT-PCS that any beneficiary may receive is 32 hours per week.

Service must be given in the week for which it was intended, based upon the POC. Under no circumstances may LT-PCS units (hours) be "banked," "borrowed," or "saved" from one prior authorized week to the next.
NOTE: A prior authorized week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. the following Saturday.

For tasks that a beneficiary can complete without difficulty or the need for physical assistance, the assistance should be limited to prompting or reminding the beneficiary to complete the task. IADL may not be performed in the beneficiary's home when the beneficiary is absent from the home, unless it is approved by OAAS or its designee and only on a case-by-case basis.

There shall be no duplication of services. LT-PCS may not be provided while the beneficiary is attending or admitted to a program or setting that provides in-home assistance with ADL and/or IADL, or while attending or admitted to a program or setting where such assistance is provided (e.g. hospitals, nursing facilities, etc.). Therefore, LT-PCS DSWs CANNOT receive payments on days that the beneficiary is attending or admitted to a program or setting that provides ADL and/or IADL assistance. In cases where a beneficiary goes to the Emergency Room (ER), the LT-PCS DSW may provide assistance up until the time the beneficiary is admitted to the hospital.

Service Exclusions

LT-PCS providers may not bill for this service until after the individual has been approved by OAAS or its designee.

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

1. Beneficiary's spouse;
2. Beneficiary's curator;
3. Beneficiary's tutor;
4. Beneficiary's legal guardian;
5. Beneficiary's designated responsible representative; or
6. Person to whom the beneficiary has given representative and mandate authority (also known as "power of attorney").

LT-PCS beneficiaries are not permitted to receive LT-PCS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed LT-PCS provider. LT-PCS providers are prohibited from providing and billing for services under these circumstances. Beneficiaries may not live in the home of their DSW unless their DSW is related to the beneficiary and this is the beneficiary's choice. (See link for "*LT-PCS DSW/Participant Relationship and Living Arrangements Guidance"* in Appendix A of this manual). These provisions may be waived with prior written approval by OAAS or its designee and only on a case-by-case basis.

LT-PCS **does not** include the following:

1. Administration of medication;
2. Insertion and sterile irrigation of catheters;
3. Irrigation of any body cavities which require sterile procedures;
4. Complex wound care;
5. Skilled nursing services as defined in State Nurse Practices Act, including administration of medications/injections, or other non-delegable nursing tasks;
6. Teaching a family member or friend how to care for a beneficiary who requires assistance with ADL;
7. Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;
8. Specialized aide procedures such as rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services), specimen collection, special skin care, decubitus ulcer care, cast care, testing urine for sugar and acetone;
9. Rehabilitative services such as those performed by an occupational therapist, speech therapist, audiologist or respiratory therapist;
10. Companionship; and/or
11. Continuous or intermittent supervision.

NOTE: LT-PCS is not designed to provide continuous or intermittent supervision to a beneficiary while informal caregivers work or are otherwise unavailable. LT-PCS is a task-oriented service tied to ADL and IADL. It is not a time-oriented sitting or supervision service.

LT-PCS and Hospice

Beneficiaries who elect hospice services may choose to elect LT-PCS and hospice services concurrently. The hospice provider and the Long-Term Care Access contractor must coordinate LT-PCS and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with LT-PCS. When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's caregiver, and the LT-PCS provider. The POC must clearly and specifically detail the LT-PCS and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating tasks where the beneficiary may receive services each day of the week.

The hospice provider must be licensed by the Louisiana Department of Health (LDH)-Health Standards Section (HSS) and must provide all hospice services as defined in 42CFR Part 418 which includes: nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies, and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, then LT-PCS can be utilized for those personal care tasks with which the beneficiary requires assistance.

Shared LT-PCS

LT-PCS may be provided by one DSW for up to three beneficiaries with LT-PCS being provided as part of their ADHC Waiver Services. The ADHC Waiver LT-PCS beneficiaries must meet the following criteria:

1. Live together; and

2. Have a common direct service provider.

Sharing of the DSW must be agreed upon by each beneficiary, and only when the health and welfare of each beneficiary can be reasonably assured. Shared LT-PCS must be identified in the approved POC for each beneficiary. Reimbursement rates are adjusted accordingly.

Due to the requirements of privacy and confidentiality, beneficiaries who choose to share these services must agree to sign a confidentiality consent form to facilitate the coordination of services. (See Appendix A for information on accessing the *Release of Confidentiality for Shared Personal Assistance Services (PAS) or Long Term-Personal Care Services (LT-PCS) form*).

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) BENEFICIARY REQUIREMENTS

Long Term – Personal Care Services (LT-PCS) are available to beneficiaries who meet the following criteria:

1. Medicaid financial eligibility;

2. Age 65 years or older, or 21 years of age or older and have a disability that meets Medicaid standards or the Social Security Administration's disability criteria;

3. Nursing facility level of care (NFLOC) requirements as determined by the Level of Care Eligibility Tool (LOCET) AND verified by the interRAI assessment;

4. Requires at least limited assistance with one or more activities of daily living (ADL). The interRAI assessment defines *limited assistance* for most ADL as the receipt of physical help or a combination of physical help and weight-bearing assistance during the assessment's look-back period;

5. Able to participate in their care and be able to direct their care independently, or through a responsible representative;

6. At imminent risk of nursing facility placement according to the following criteria:

    a. In a nursing facility and could be discharged if home and community-based services (HCBS) were available;

    b. Be likely to require nursing facility admission within the next 120 calendar days as determined by the assessment or supporting documentation; or

    c. Has a primary caregiver who has a disability or is age 70 or older.

Failure of an individual to meet or maintain any of the above listed criteria will result in denial of admission to/discharge from the LT-PCS program.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) BENEFICIARY RIGHTS AND RESPONSIBILITIES

Beneficiaries have specific rights and responsibilities that accompany eligibility and participation in Medicaid programs. Office of Aging and Adult Services (OAAS), or its designee, and providers must assist beneficiaries in exercising their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. Providers are bound by their agreement, with Medicaid, to adhere to the following policies on beneficiary rights.

Each individual who requests Long Term – Personal Care Services (LT-PCS) has the option to designate a responsible representative to assist or act on their behalf in the process of accessing and/or maintaining LT-PCS. The beneficiary has the right to change their responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than 2 beneficiaries in a Medicaid Home and Community-Based Services (HCBS) program that is operated by OAAS (unless an exception is granted by OAAS) which includes, but is not limited to, the following:

1. Program of All-Inclusive Care for the Elderly (PACE);
2. LT-PCS;
3. Community Choices Waiver (CCW); and
4. Adult Day Health Care (ADHC) Waiver.

Rights and Responsibilities Form

OAAS, or its designee, is responsible for reviewing the beneficiary's rights and responsibilities with the beneficiary and/or their personal representative as part of the initial intake process and at least annually thereafter. (See Appendix A for information on accessing the *OAAS Rights and Responsibilities for LT-PCS Applicants/Participants* form).

Freedom of Choice of Providers

Beneficiaries have the freedom of choice (FOC) to select their providers. A list of enrolled providers is given to the beneficiary at every assessment visit. When the beneficiary chooses a provider, or chooses to change their provider, the beneficiary must contact OAAS or its designee.

Beneficiaries may make provider changes based on the following schedule:

Type of Service	Without Good Cause	With Good Cause
LT-PCS	Every 3 months based on a calendar quarter	Any time

Good cause is defined as:

1. A beneficiary moving to another region in the state where the current provider does not provide services;

2. A beneficiary and a provider having unresolved difficulties and mutually agreeing to a transfer;

3. A beneficiary's health or welfare having been compromised; or

4. A provider not rendering services in a manner satisfactory to the beneficiary.

OAAS, or its designee, will provide beneficiaries with their choice of providers and help arrange and coordinate all the services on the plan of care (POC).

Changing Providers

All requests for change of provider must be submitted in writing to the long term care (LTC) access contractor. Providers will receive written notification when approval has been given for beneficiaries to change providers.

Adequacy of Care

Beneficiaries have the responsibility to request only those services that are necessary and not request excess services, or services for the convenience of employees or providers. Units of service are not "saved up". The services are certified as medically necessary for the beneficiary to be able to stay in the community and are revised on the POC as each beneficiary's needs change. OAAS, or its designee, must be informed any time there is a change in the beneficiary's health, medication, physical conditions, caregiver status, and/or living situation.

Participation in Care

Each beneficiary must participate in the assessment and person-centered planning meetings and any other meeting involving decisions about services and supports to be provided. Each beneficiary may choose whether or not providers attend assessment and planning meetings. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary's needs. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services. The beneficiary is expected to participate in the planning process to the best of the beneficiary's ability so that services can be delivered according to the approved person-centered POC. Changes in the amount of services may be requested by the beneficiary or by a provider on behalf of the beneficiary. OAAS, or its designee, will verify **ALL** requests with the beneficiary.

Voluntary Participation

Beneficiaries have the right to refuse services and to know the consequences of their decisions. Therefore, a beneficiary will not be required to receive services or participate in activities that they do not want, even if they are eligible for these services. The intent of LT-PCS is to provide community-based services to individuals who would otherwise require care in a nursing facility.

Quality of Care

Each LT-PCS beneficiary has the right to be treated with dignity and respect and receive services from providers and their employees who have been trained and are qualified to provide them. In addition, providers are required to maintain privacy and confidentiality in all interactions related to the beneficiary's services.

Beneficiaries have the right to be free from abuse (mental, physical, emotional, coercion, restraints, seclusion, and any other forms of restrictive interventions).

In cases where services are not delivered according to the approved POC, or there are allegations of abuse, neglect, exploitation, or extortion, the beneficiary must follow the reporting procedures and inform the provider and appropriate authorities.

Beneficiaries and providers must cooperate in the investigation and resolution of reported incidents/complaints.

Civil Rights

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

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for LT-PCS beneficiaries. In order to maintain eligibility, beneficiaries and providers have the responsibility to inform BHSF of changes in the beneficiary's income, resources, address, and living situation.

OAAS or its designee is responsible for approving level of care (LOC) and medical certification. Beneficiaries and their providers have the responsibility to inform OAAS, or its designee, of any changes which affect programmatic eligibility requirements, including changes in LOC.

Grievances/Complaints

The beneficiary has a responsibility to bring problems to the attention of providers or OAAS, or its designee, and to file a grievance/complaint without fear of retribution, retaliation, or discharge.

All direct service providers (DSPs) must have grievance procedures through which beneficiaries may voice complaints regarding the supports or services they receive. Beneficiaries must be provided a copy of the grievance procedures upon admission to a DSP and complaint/grievance forms shall be given to beneficiaries thereafter upon request. It is the beneficiary's right to contact any advocacy resource as needed, especially during grievance procedures.

If beneficiaries need assistance, clarification, or to report a complaint, toll-free numbers are available (*See Appendix B for contact information*).

Fair Hearings

Beneficiaries must be advised of their rights to appeal any action or decision resulting in an adverse action or determination. This includes: denials, suspension, reduction, discontinuance, or termination of services. Beneficiaries have the right to a fair hearing through the Division of Administrative Law (DAL). In the event of a fair hearing, a representative of the DSP must participate by telephone, or in person, if requested.

An appeal by the beneficiary may be filed with DAL via fax, mail, online request, by telephone, or in person. (See Appendix B for contact information). Instructions for submitting appeals/requests for a fair hearing are also included in all adverse action notices.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) SERVICE ACCESS AND AUTHORIZATION

After the assessment and any other documentation are reviewed to determine if the beneficiary meets nursing facility level of care (NFLOC) and other program requirements, the plan of care (POC) is developed based on the results. The POC includes the:

1. Type of supports needed; and

2. Amount of services needed.

Provider Selection

At the in-home assessment visit, the Long Term Care (LTC) Access contractor provides a current list of enrolled Medicaid Long Term – Personal Care Services (LT-PCS) providers in the region. The beneficiary is instructed to contact providers in order to make their selection. This enables the beneficiary to have freedom of choice (FOC) for the provider who will administer services, if they are eligible for LT-PCS. It is the beneficiary's responsibility to inform the LTC Access contractor of their decision.

The contractor will send the selected provider the "Agreement to Provide Services" form. Providers will need to meet with the beneficiary to review the POC and discuss provision of the services.

If the provider agrees to provide the services, the "*Agreement to Provide Service*s" form must be signed and returned to the LTC assess contractor within 14 calendar days. If approved for services, an approval notice is mailed to the beneficiary along with a copy of the POC and the approved interRAI assessment. (Refer to Appendix B for contractor information).

If the chosen provider declines to serve an individual, the provider must provide to the Office of Aging and Adult Services (OAAS) or its designee, written documentation that supports an inability to meet the individual's needs, or documentation that all previous efforts to provide services and supports have failed and there is no option but to refuse services. The individual will then be asked to choose another provider.

Prior Authorization

All services under LT-PCS must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid beneficiary by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and to ensure that it meets criteria for reimbursement. PA does not guarantee

payment for the service as payment is contingent upon the passing of all edits contained within the claims payment process, the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service.

PA revolves around the POC document, which means that only the amount of services specified in the approved POC will be prior authorized. A PA number is assigned, and approved units of service are released on a weekly basis to the provider. The approved units of service must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning midnight Sunday and ending at 11:59 pm the following Saturday.

A PA number will be issued to providers for the service authorization period, unless the beneficiary changes providers.

Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The provider is responsible for the following activities:

1. Checking PAs by accessing Medicaid Eligibility Verification System (MEVS)/ Recipient Eligibility Verification System (REVS) at the beginning of each month to verify that all PAs for services match the approved services in the beneficiary's POC. Any mistakes must be immediately corrected;
2. Verifying that services were documented as specified in Section 30.8 – Record Keeping, and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;
3. Verifying that services were delivered according to the beneficiary's approved POC prior to billing for the service;
4. Proper use of the Electronic Visit Verification (EVV) system;
5. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;
6. Billing only for the services that were delivered to the beneficiary and approved in the beneficiary's POC;
7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary (FI) with each payment; and

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

   NOTE: Providers have one-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in Chapter General Information and Administration of the *Medicaid Services Manual* at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

All requests for changes in services and/or service hours must be made by the beneficiary or their responsible representative. A status change assessment will be performed for all requests where a change in the beneficiary's level of functioning is reported and verified.

Re-assessments will be conducted at least once every 18 months to determine ongoing qualification for services.

Post Authorization

LT-PCS requires post authorization before the provider is able to bill for services rendered. Post authorization is verified through EVV.

The data contractor checks the information reported against the prior authorized units of service. Once post authorization is granted, the provider may bill the LDH FI for the appropriate units of service.

Changing Providers

All requests for changes in providers require a new FOC by the beneficiary or their responsible representative. (Refer to 30.4-Beneficiary Rights and Responsibilities, FOC of Providers, for details on "good cause" criteria and timelines).

OAAS, or its designee, will provide the beneficiary with the current FOC provider list for their region. Once a new provider has been selected, OAAS or its designee will ensure the new provider is notified of the request. Both the transferring provider and the receiving provider share responsibility for ensuring the exchange of medical and program information which includes:

1. Progress notes from the last 6 months, or if the beneficiary has received services from the provider for less than 6 months, all progress notes from date of admission;

2. Current Individualized Service Plan (ISP), current assessments upon which the ISP is based (if applicable);

3. Documentation of the amount of authorized services remaining in the POC including direct service case record documentation; and

4. Documentation of exit interview.

OAAS or its designee will facilitate the transfer of the above referenced information to the receiving provider and forward copies of the following to the new provider:

1. Most current POC;

2. Current assessments on which the POC is based;

3. Number of services used in the calendar year; and

4. All documents necessary for the new provider to begin providing services.

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

Prior Authorization for New Providers

OAAS or its designee will complete a POC revision that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the POC revision. The transferring provider's PA number will expire on the end date as indicated on the POC revision.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) PROVIDER REQUIREMENTS

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

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

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

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

Refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf. Section 1.1 - Provider Requirements contains detailed information concerning topics relative to Medicaid provider enrollment.

Providers must not

1. Have been terminated or actively sanctioned by Medicaid, Medicare or any other health-related programs in Louisiana or any other state; and

2. Have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Providers are required to:

1. Complete a criminal history background check for all potential new employees, including supervisors and contractors;

2. Retain the results of the criminal history and background checks as documentation;

3. Not hire individuals that have criminal convictions preventing employment that are listed under 42 CFR 441.404(b) and listed in Louisiana Revised Statute (R.S.) 40:1203.01 et. seq. and any other applicable state law;

4. Complete the following database checks for potential new employees, upon hire, and for current employees, on a monthly basis:

a. Louisiana State Adverse Actions List Search; and

NOTE: This database now includes information from the DSW Registry.

b. Office of Inspector General (OIG) List of Excluded Individuals.

5. Retain the results of the database checks' print outs/documents as proof that the search was conducted; and

NOTE: Regardless of the search results, the providers MUST keep the documentation that the search was conducted.

6. Not hire the individual as an employee or allow the employee to continue working for you, if their name appears on one of the database searches/lists.

NOTE: For instructions and details on the database checks, please see Appendix D – Database Checks.

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

1. Recoupment;

2. Sanctions;

3. Loss of enrollment; or

4. Loss of licensure.

Providers must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment and continued participation as a waiver provider. A Provider Enrollment Packet must be completed by the provider for each provider type and for each LDH administrative region in which the agency or provider will deliver services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number for that provider type.

Long Term – Personal Care Services (LT-PCS) are to be provided strictly in accordance with the provisions of the approved plan of care (POC). All providers and/or contractors are obligated to immediately report any changes to LDH that could affect the beneficiary's eligibility.

Providers are responsible for documenting the occurrence of incidents or accidents according to their company's policy.

Providers must:

1. Participate in all training for prior authorization (PA) and data collection. Initial training is provided at no cost to the provider. Any repeat training must be paid for by the requesting provider; and

2. Have available computer equipment software, and internet connectivity necessary to participate in PA, data collection, and Electronic Visit Verification (EVV).

Licensure and Specific Provider Requirements

Providers must meet licensure and other additional requirements as outlined in the table below:

Personal Care Services
Provided by a PCS provider that: 1. Is licensed by the LDH Health Standards Section (HSS) as a PCS provider; 2. Has enrolled in Medicaid as a PCS provider; and 3. Is listed on the FOC form.

Provider Responsibilities

LT-PCS providers must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable LDH and the Office of Aging and Adult Services (OAAS) rules and policies.

All LT-PCS providers must pay their direct service worker (DSW) a minimum wage floor of $9.00 per hour.

Effective 10/1/22, all LT-PCS providers must pass 70% of their rate increase to DSWs in the form of a minimum wage floor of $9.00 per hour **AND** in other wage and non-wage benefits. This applies to all DSWs of any working status, whether full-time or part-time and includes contractor workers.

LT-PCS providers must have a detailed policy that includes the specific methods that they will use to pass 70% of their rate increases to their DSWs. There are certain wage and non-wage benefits have been authorized by LDH/OAAS. (See Appendix E for this listing).

Any additional benefits not listed in Appendix E **MUST** be pre-approved by OAAS before the benefit is added to the provider's policy, or, prior to being provided to the DSW. Providers must email their proposed additional benefits to OAAS at OAAS.ProviderRelations@la.gov. OAAS will respond to the provider within 10 business days from the date of the submitted email.

NOTE: OAAS does NOT need to approve the provider's policy pertaining to the wage and non-wage benefit requirements. Providers must ONLY send their requests to OAAS if they would like to use other benefits that are not listed above.

LT-PCS providers may be audited by LDH or its designee to ensure compliance with wage floor and wage and non-wage benefits. For audit procedures, refer to Appendix F.

Providers shall not refuse to serve any beneficiary who chooses their agency, unless there is documentation to support an inability to meet the beneficiary's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. OAAS, or its designee, must be notified immediately of the circumstances surrounding the refusal. The refusal request must be made in writing by the provider to OAAS, or its designee, and to the beneficiary detailing why the provider is unable to serve the beneficiary. This requirement can only be waived by OAAS or its designee.

Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

If the provider proposes **involuntary transfer, discharge of a beneficiary, or if a provider closes** in accordance with licensing standards, the following steps must be taken:

1. The provider shall give written notice to the beneficiary, a family member and/or the responsible representative, if known, at least 30 calendar days prior to the transfer or the discharge;

2. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the beneficiary understands;

3. A copy of the written discharge/transfer notice shall be put in the beneficiary's record;

4. When the safety or health of beneficiaries or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge; and

5. The written notice shall include the following:

    a. A reason for the transfer or discharge;

b. The effective date of the transfer or discharge;

c. An explanation of a beneficiary's right to personal and/or third party representation at all stages of the transfer or discharge process;

d. Contact information for the Advocacy Center;

e. Names of provider personnel available to assist the beneficiary and family in decision making and transfer arrangements;

f. The date, time and place for the discharge planning conference;

g. A statement regarding the beneficiary's appeal rights;

h. The name of the director, current address and telephone number of the Division of Administrative Law (DAL); and

i. A statement regarding the beneficiary's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

1. Holding a transfer or discharge planning conference with the beneficiary, family, support coordinator, legal representative and advocate, if such is known;

2. Developing discharge options that will provide reasonable assurance that the beneficiary will be transferred or discharge to a setting that can be expected to meet their needs;

3. Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the beneficiary; and

4. Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

NOTE: The requirements above do not apply when the beneficiary is being discharged from the LT-PCS program by LDH or OAAS.

Failure of the provider to meet the minimum standards shall result in a range of required corrective actions including, but not limited to, the following:

1. Removal from the FOC listing;

2. A citation of deficient practice;

3. A request for corrective action plan; and/or

4. Administrative sanctions.

Continued failure to meet the minimum standards may result in disenrollment as an LT-PCS provider.

Cost Reports

LT-PCS providers must:

1. Submit annual cost reports with a fiscal year from July 1st through June 30th to LDH or its contractor in order to verify expenditures and to support rate setting for the services rendered to LT-PCS participants; and

2. Complete and submit the LDH approved cost report(s) to the LDH or its contractor no later than November 30th, which is five months after the state's June 30th fiscal end date. (See Appendix B to obtain web address for additional information).

When the provider fails to submit the required cost report(s) by November 30th, a penalty of five percent of the total monthly payment for the 1st month and a progressive penalty of five percent of the total monthly payment for each succeeding month may be levied and withheld from the provider's payment for each month that the cost report is due, not extended and not received. If no claims are submitted for payment during the time of the penalty implementation, the penalty will be imposed when the provider commences submitting claims for payment. The late filing penalty is non-refundable and not subject to an administrative appeal.

Back-up Staffing Plan

Providers must have a written back-up plan for each LT-PCS beneficiary in the event the assigned worker is unable to provide support due to unplanned circumstances or emergencies which may arise. This plan must be developed and maintained in accordance with licensing standards and include:

1. Person or persons responsible for back up coverage (including names, relationships, and contact phone numbers);

2. A toll-free telephone number with 24-hour availability manned by an answering service that allows the beneficiary to contact the provider if the worker fails to show up for work; and

3. Signatures and dates.

If providers use a pool of on-call or substitute workers to ensure that services to the beneficiary will not be interrupted, those workers must meet the same qualifications as the regular LT-PCS workers.

In all instances when a worker is unable to provide support, they must contact the provider and family/beneficiary immediately.

Back-up staffing plans **must** be provided to beneficiaries and/or their personal representative before services begin.

Emergency Plan

Providers must also ensure that each beneficiary has a documented individualized emergency plan in preparation for, and response to, emergencies and disasters that may arise. This plan must identify specific resources available through family, friends, the neighborhood and the community.

Worker Qualifications

All staff providing direct care to the beneficiary must meet the qualifications set forth in the licensing regulations found in the Louisiana Administrative Code (LAC Title 48, Chapter 50 and Chapter 92).

Family members who provide LT-PCS must meet the same standards for employment as caregivers who are unrelated to the beneficiary. (Refer to the link in Appendix A for further clarification).

Changes

Changes in the following areas are to be reported in writing to HSS, OAAS and the fiscal intermediary's (FI's) Provider Enrollment Section, within the time specified in the HSS licensing rule:

1. Provider's entity name ("doing business as" name);

2. Key administrative personnel;

3. Ownership;

4. Physical location;

5. Mailing address;

6. Telephone number; and

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

When a provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 30 calendar day written advance notice to all beneficiaries served and their responsible representatives, and LDH (OAAS and HSS) prior to discontinuing service.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) SERVICE DELIVERY

Plan of Care/Plan of Care Revisions

The Office of Aging and Adult Services (OAAS) or its designee will develop the plan of care (POC) to correlate with the beneficiary's needs identified in the interRAI Home Care (iHC) assessment. Those tasks/activities covered under Long-Term - Personal Care Services (LT-PCS) will be outlined in the POC and include the following:

1. Specific activities of daily living (ADL) and instrumental activities of daily living (IADL) tasks in which the individual requires assistance; and

2. How the LT-PCS worker is to perform the ADL and/or IADL tasks (e.g. assist or cue the beneficiary, etc.).

3. Frequency of service for each task/activity:

    a. Number of days per week each task/activity will be performed; and

    b. Preferred time of day to accomplish each task/activity (when the time is pertinent, such as when to prepare meals).

This POC will be sent by the Long Term Care (LTC) Access contractor to the chosen provider in the provider notice packet.

LT-PCS approvals are **NOT** based on the time per task/activity.

The focus is on documenting that the task/activity required in the POC is actually performed.

Weekly units of service must not be more than the units specified in the POC. Beneficiaries have the flexibility to use the weekly LT-PCS units (hours) according to their preferences and personal schedule within the prior authorized week.

During brief periods (less than 30 calendar days duration), the provider may deviate from the POC.

If POC deviations extend beyond 30 calendar days **or** there are continuous deviations from the POC **or** when an apparently permanent change in the beneficiary's level of functioning and/or an availability of other supports is noted, the beneficiary or responsible representative should request a status change assessment to determine if the POC needs to be revised. Status change assessments may result in the number of hours approved being decreased, increased, or remaining the same.

Location of Service

LT-PCS must be provided in the beneficiary's home or can be provided in another location outside of the beneficiary's home if the provision of these services allows the beneficiary to participate in normal life activities as they pertain to ADL and IADL cited in the POC. Services that are provided in the beneficiary's home must be provided while the beneficiary is present. The beneficiary's home is defined as the place where the beneficiary resides such as: a house, apartment, a boarding house, or the house or apartment of a family member or unpaid primary caregiver. When a beneficiary visits a hospital's emergency room (ER), the LT-PCS worker may provide assistance until the beneficiary is admitted to the hospital.

When a beneficiary plans to go on a trip/travel outside of Louisiana, but still within the United States, while receiving LT-PCS, they must submit a written request to OAAS at least 24 hours prior to the anticipated trip/travel (when applicable). OAAS must approve the request prior to the out of state service delivery (when applicable). These requests must be sent to OAAS.Inquiries@LA.gov and include the following:

1. Participant's first and last name;
2. Participant's date of birth (DOB);
3. Span and/or duration of the trip;
4. Physical address where services will be provided out of state; and
5. Reason(s) why services must be provided out of state.

OAAS and/or its designee regularly monitors and audits out of state delivery. Out of state service delivery without documented approval will be referred to the Louisiana Department of Health (LDH) Program Integrity Section for fraud review.

Medicaid does **NOT** cover or pay for services provided outside of the United States.

Interruption of Services

A beneficiary may go without services up to **30 calendar days** without being discharged from the program.

Interruption of services is permissible under the following circumstances:

1. An acute care hospital admission;

2. Temporary stay in another type of care facility (e.g. nursing facility, rehabilitation hospital, etc.); or

3. A temporary stay outside the home (e.g., a vacation, etc.).

Reimbursement is not available during service interruption periods.

Discontinuation of Services

A provider must give written notification to the beneficiary or the responsible representative when discontinuing services for a good cause. (Refer to Section 30.6 – Provider Requirements of this manual chapter). This notice must be written and delivered in accordance with all LDH rules.

A provider may discontinue services to a beneficiary without a 30 calendar day notice under the following circumstances:

1. Upon the beneficiary's request;

2. If the beneficiary's hospitalization is expected to last more than 30 calendar days, the provider may terminate services because of the unavailability of the beneficiary to receive services. When the beneficiary is discharged and returns home, they may choose the same provider or another provider to continue receipt of services;

3. Unsafe working conditions prevent the worker from performing their duties or threaten the worker's personal safety (e.g., unsanitary conditions, illegal activities in the home, etc.). The provider must make a documented, reasonable effort to notify the beneficiary and/or the personal representative of the unsafe working conditions in the home and attempt to resolve the problem. At the same time, OAAS, or its designee, should be notified of the provider's concerns for staff's safety;

4. Beneficiary no longer meets the Medicaid financial eligibility criteria;

5. Beneficiary no longer meets LT-PCS program requirements;

6. Beneficiary is incarcerated or placed under the supervision of the judicial system;

7. Beneficiary is admitted to a LTC facility; or

8. Beneficiary moves out of the service area (permanently or for a period over 30 calendar days).

If services are to be discontinued, the provider must notify the LTC Access contractor **within 24 hours prior to action being taken. (**See Appendix B of this manual chapter for contact information).

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) RECORD KEEPING

Refer to the *Medicaid Services Manual*, Chapter 1 General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf.

Components of Record Keeping

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

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

Retention of Records

The provider must retain administrative, personnel and beneficiary records for a minimum of six years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six years).

NOTE: Upon provider closure, all provider records must be maintained according to applicable laws, regulations, and the above record retention requirements. Copies of the required documents must also be transferred to the new provider.

Confidentiality and Protection of Records

Records, including administrative and beneficiary records, must remain the property of the provider and be secured against loss, tampering, destruction or unauthorized use.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, the beneficiaries or their families, directly or indirectly, to any

unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiary or their family.

The information may be released only under the following conditions:

1. Court order;

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

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

4. Compliance with the Federal Law, Confidentiality of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

A provider must, upon request, make available information in the case records to the beneficiary or legally responsible representative. If, in the professional judgment of the administration of the provider, it is felt that the information contained in the record would be damaging to the beneficiary, that information may be withheld from the beneficiary except under court order.

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

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

Any electronic communication containing beneficiary-specific identifying information sent by the provider to another agency, or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system.

Beneficiary records must be located at the enrolled site.

NOTE: Under no circumstances shall providers allow staff to remove beneficiary records from the provider site.

Review by State and Federal Agencies

Providers must make all administrative, personnel, and beneficiary records available to LDH, or its designee, and appropriate state and federal personnel within the specified timeframe given by LDH or its designee. Providers must always safeguard the confidentiality of beneficiary information. The provider is responsible for incurring the cost of copying records.

Beneficiary Records

Providers must have a separate written record for each beneficiary. To ensure continuity of care, the record must have on-going, adequate, chronological documentation of activities/services that have been offered and provided. Services provided must be clearly related to the services documented in the beneficiary's plan of care (POC).

Records at the Beneficiary's Home

Providers must maintain the following documents at the beneficiary's home:

1. **Current** copy of the beneficiary's POC and POC revision (if applicable); and

2. Copies of the beneficiary's service logs for the current prior authorized week. (A prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Saturday at 11:59 p.m.).

   Example: If LDH staff or designee goes into the home on a Wednesday, service logs for that day, along with the applicable documentation (if services were performed) from that Sunday, Monday, and Tuesday (the current prior authorized week) are required.

   NOTE: A copy of the "Long-Term Personal Care Services (LT-PCS) Log", along with instructions for using and completing this form, can be found in Appendix A.

LDH or its designee may request copies of these records and, at its discretion, may also request additional records from the provider. Records shall be made available to the requestor in accordance with LDH policy.

See below for specific information regarding documentation for LT-PCS:

Long Term-Personal Care Services (LT-PCS)	
Service Log	Complete the task checklist **after** each activity has been performed and/or supports have been provided. Page two of the service log (progress notes) shall be completed, as applicable, to reflect observed changes and other important information about the beneficiary. (Refer to Appendix A for form and instructions).
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Organization of Records, Record Entries and Corrections

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

All entries and forms completed by staff in beneficiary records must be legible, written in ink (if not completed electronically) and include the following:

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

Any error made in a beneficiary's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it, and initial the correction**. Correction fluid must NEVER be used in a beneficiary's records**. The provider's office staff may not change any of the documentation entered by the LT-PCS worker.

Service Logs

Service logs document the services provided and billed. These service logs are the "paper trail" for services delivered by the worker.

Service logs contain the following information:

1. Name of beneficiary;
2. Name of provider and employee providing the service;
3. Date of service contact; and
4. Content of service contact.

NOTE: The start and stop time of service contacts, as well as the location where check in/check out occurs, are captured through the use of an electronic visit verification (EVV) system.

A separate service log must be kept for each beneficiary. Reimbursement is only payable for services documented in the service log and captured through EVV. **Providers are required** to use the LT-PCS service log issued by the Office of Aging and Adult Services (OAAS). (See Appendix A for information on accessing this form and the associated instructions).

All portions of the service log must be completed each week. Photocopies of previously completed service logs will not be accepted.

Service logs must be:

1. Completed **daily as tasks are performed.** (Service logs may not be completed prior to the performance of a task); and
2. Signed and dated by the worker and by the beneficiary or responsible representative **after the work has been completed at the end of the week**.

Progress notes are located on the 2nd page of the service log and are the means of documenting:

1. Observed changes in the beneficiary's mental and/or medical condition(s), behavior or home situation that may indicate a need for a reassessment and POC, and/or Individualized Service Plan (ISP) change (as applicable); and
2. Other information important to ensure continuity of care.

NOTE: If a beneficiary, for any reason, does not use all or part of their LT-PCS hours on a particular day, but the unused LT-PCS hours were used in other days throughout that week, how the hours were used and the justification or need for the hours on that day **must** be clearly documented. When hours are not used, they **cannot** be used later in the week just to "make up" the hours; therefore, workers **cannot** do the same task/activity twice in one day just to "make up" the unused hours. There **must** be an **actual** need for the unused hours on the day that they are used.

Examples of when to document in a narrative progress note include but are not limited to:

1. More assistance provided than what is indicated in the POC due to the beneficiary's request or their increased need; and
2. Assistance not provided with a particular task/subtask as indicated in the POC due to beneficiary's request or their lack of need.

When progress notes are written/entered, they must:

1. Be legible;
2. Include the date of the entry;
3. Include the name of the person/worker making the entry; and
4. Be completed and updated in the record in the time specified.

Each provider's documentation shall support justification for PA or payment of services. Services billed must clearly be related to the current approved POC and ISP, if applicable.

NOTE: Service logs (including the progress notes section) can be completed, signed, initialed and/or dated electronically, as long as the provider complies with all service log requirements identified in this manual, as well as the State and HIPAA requirements. If providers use an electronic version of the service log, it must be identical to the approved OAAS service log.

If OAAS or its designee discovers that providers and/or the worker is not adhering to the OAAS service log requirements, the provider and/or worker may be referred to Program Integrity.

Transfers and Closures

A progress note **must** be entered in the beneficiary's record when a case is transferred or closed.

A discharge summary detailing the beneficiary's progress must also be entered in the beneficiary's record prior to a transfer or closure. This summary must be completed within 14 calendar days following a beneficiary's discharge.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) INCIDENTS, ACCIDENTS, AND COMPLAINTS

Long Term – Personal Care Services (LT-PCS) staff must report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion to the on-duty supervisor immediately and as mandated by law to the appropriate entity (Adult Protective Services (APS) or Elderly Protective Services (EPS)). Any illegal activities **MUST** be reported to law enforcement. Reporting to a supervisor only, **does not** satisfy the legal requirement to report. The supervisor is responsible for ensuring that a report or referral is made, in a timely manner, to the appropriate entity.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of all incidents and accidents involving the beneficiary that occurred during the course of delivering services. The incident/accident report must be maintained in the beneficiary's record. The report must include:

1. Beneficiary identifying information;
2. Event information (including date, time, location, etc.) of the incident/accident;
3. Circumstances surrounding the incident/accident;
4. Description of incident/accident (including any medical attention or law enforcement involvement, witnesses, etc.);
5. Action taken to correct or prevent future occurrences of the incident/accident; and
6. Name of person completing the report.

Imminent Danger and Serious Harm

Providers must report all suspected cases of abuse (physical, mental, emotional, and/or sexual), neglect, exploitation or extortion to the appropriate authority. In addition, any other circumstances that place the beneficiary's health and well-being at risk shall be reported to the appropriate authorities. (See Appendix B of this manual chapter for contact information).

For beneficiaries ages 18 through 59 and emancipated minors, APS must be contacted. APS investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect,

exploitation or extortion. (See Appendix B of this manual chapter for contact information).

For beneficiaries age 60 or older, EPS must be contacted. EPS investigates situations of abuse, neglect and/or exploitation of individuals age 60 or older. (See Appendix B of this manual chapter for contact information).

If the beneficiary needs emergency assistance, the worker must call 911 or the local law enforcement agency before contacting the supervisor.

Internal Complaint Policy

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

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

2. All written complaints should be forwarded to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator;

3. The complaint coordinator must send a letter to the complainant acknowledging receipt of the complaint **within 5 working days**;

4. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the beneficiary, the personal representative, the worker, and other interested parties. The provider is encouraged to use all available resources to resolve the complaint internally. The LT-PCS supervisor must be informed of the complaint and the resolution;

5. The provider must inform the beneficiary, the complainant, and/or the responsible representative in writing **within 10 working days** of receipt of the complaint, the results of the internal investigation; and

6. If the beneficiary is dissatisfied with the results of the provider's internal investigation, they may continue the complaint resolution process by contacting the Health Standards Section (HSS). (See Appendix B of this manual chapter for contact information).

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) REIMBURSEMENT

Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier. (Refer to Appendix C in this manual chapter for information about procedure code, unit of service and current reimbursement rate).

Reimbursement must not be made for services provided prior to approval of the plan of care (POC) and release of prior authorization (PA) for these services.

Medicaid 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 provider to recoupment of funds previously paid by Medicaid. Third parties include, but are not limited to, the following:

1. Private health insurance;
2. Casualty insurance;
3. Worker's compensation;
4. Estates;
5. Trusts;
6. Tort proceeds; and
7. Medicare.

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

Long Term – Personal Care Services (LT-PCS) providers are reimbursed at a per quarter-hour (15 minutes) rate for services under a prospective payment system (PPS) that recognizes and reflects the cost of direct care services provided.

NOTE: Reimbursement for transportation during the delivery of LT-PCS services is not available. As a result, if a LT-PCS provider decides to provide transportation to the LT-PCS participants, they will not be reimbursed for transportation expenses.

Release of PA for LT-PCS is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. EVV is mandatory for LT-PCS. 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 the Office of Aging and Adult Services (OAAS). The system is to be used to electronically "check in" and "check out" when the LT-PCS worker begins and when they end service delivery to 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 beneficiary under shared LT-PCS (through the Adult Day Health Care (ADHC) Waiver), must bill separately for each beneficiary based on their POC. Each beneficiary must be present to receive the shared service in order for the provider to bill for the service.

Span Date Billing

Claims cannot be span-dated for a specified time-period. Each line on the claim form must represent billing for a single date of service.

See Section 30.5 – *Service Authorization Process* of this manual chapter for details about when claims for LT-PCS may be filed.

Rate Methodology

A rate validation process will occur every two years, at a minimum, to determine the sufficiency of reimbursement rates. The rate validation process will involve the comparison of current provider reimbursement rates to reimbursement rates established using the Department's reimbursement methodology.

1. The Department's reimbursement methodology will establish an estimated reimbursement through the summation of the following two rate component totals:

    a. Adjusted staff cost rate component; and

    b. Other operational cost rate component.

2. The adjusted staff cost rate component will be determined in the following manner:

a. Direct service worker (DSW) wage expense, contract labor expense, and hours worked for reimbursable assistance services will be collected from the provider cost reports;

i. Collected wage and contract labor expense will be divided by collected hours worked, on an individual cost report basis, to determine a per hour labor rate for DSWs; and

ii. Individual cost report hourly labor rates will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide labor rate will be determined.

b. A blended DSW labor rate will be calculated by comparing the simple average statewide labor rate to the most recently available, as of the calculation of the Department's rate validation process, average personal care aide wage rate from the Louisiana Occupational Employment and Wages report for all Louisiana parishes published by the Louisiana Workforce Commission (or its successor);

i. If the simple average statewide labor rate is less than the wage rate from the Louisiana Occupational Employment and Wages report, a blended wage rate will be calculated using 50% of both wage rates; and

ii. If the simple average statewide labor rate is equal to or greater than the wage rate from the Louisiana Occupational Employment and Wages report, the simple average statewide labor rate will be utilized.

c. An employee benefit factor will be added to the blended DSW wage rate to determine the unadjusted hourly staff cost;

i. Employee benefit expense allocated to reimbursable assistance services will be collected from provider cost reports;

ii. Employee benefit expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate employee benefits as a percentage of labor costs;

iii. Individual cost report employee benefit percentages will be aggregated for all applicable filed cost reports, outliers will be

removed, and a simple average statewide employee benefit percentage will be determined; and

iv. The simple average statewide employee benefit percentage will be multiplied by the blended DSW labor rate to calculate the employee benefit factor.

d. The Department will be solely responsible for determining if adjustments to the unadjusted hourly staff cost are considered appropriate. Adjustments may be considered for items that are underrepresented or not represented in provider cost reports;

e. The unadjusted hourly staff cost will be multiplied by a productive hours adjustment to calculate the hourly adjusted staff cost rate component total. The productive hour's adjustment allows the reimbursement rate to reflect the cost associated with DSW time spent performing required non-billable activities. The productive hours adjustment will be calculated as follows:

i. The Department will determine estimates for the amount of time a DSW spends performing required non-billable activities during an eight hour period. Examples of non-billable time include, but are not limited to: meetings, substitute staff, training, wait-time, supervising, etc.;

ii. Total time associated with DSW non-billable activities will be subtracted from the eight hours to determine DSW total billable time; and

iii. Eight hours will be divided by the DSW total billable time to calculate the productive hours' adjustment.

3. The other operational cost rate component will be calculated in the following manner:

a. Capital expense, transportation expense, other direct non-labor expense, and other overhead expense allocated to reimbursable assistance services will be collected from provider cost reports;

b. Capital expense, transportation expense, supplies and other direct non-labor expense, and other overhead expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract

labor expense for reimbursable assistance services to calculate other operational costs as a percentage of labor costs;

c. Individual cost report other operational cost percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide other operational cost percentage will be determined; and

d. Simple average other operational cost percentage will be multiplied by the blended DSW labor rate to calculate the other operational cost rate component.

4. The calculated department reimbursement rates will be adjusted to a one quarter hour unit of service by dividing the hourly adjusted staff cost rate component and the hourly other operational cost rate component totals by four; and

5. The Department will be solely responsible for determining the sufficiency of the current reimbursement rates during the rate validation process. Any reimbursement rate change deemed necessary due to the rate validation process will be subject to legislative budgetary appropriation restrictions prior to implementation.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) FRAUD AND ABUSE

General

Federal regulations require that the Louisiana Medicaid program establish criteria that are consistent with principles recognized as affording due process of law for identifying situations where there may be fraud or abuse, for arranging prompt referral to authorities, and for developing methods of investigation or review that ascertain the facts without infringing on the legal rights of the individuals involved.

Fraud

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. The definition of fraud that governs between citizens and government agencies is found in Louisiana R.S. 14:67 and R.S. 14:70.01. Legal action may be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-3). Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts. All such legal action is subject to due process of law and to the protection of the rights of the individual under the law.

Provider Fraud

Cases involving one or more of the following situations constitute sufficient grounds for a provider fraud referral:

1. Billing for services that are not rendered to, or used for, Medicaid beneficiaries;

2. Claiming costs for non-covered or non-chargeable services disguised as covered items;

3. Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the beneficiary of the services;

4. Submitting duplicate billing to the Medicaid program or to the beneficiary, which appears to be a deliberate attempt to obtain additional reimbursement;

5. Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid; and

6. Coaching applicant/beneficiary on how to respond to assessment questions in order to appear eligible for services.

Beneficiary Fraud

Providers should refer to the *Medicaid Services Manual*, Chapter 1 General Information and Administration, for a description of beneficiary fraud.

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) PROGRAM OVERSIGHT AND REVIEW

Services offered through the Long Term – Personal Care Services (LT-PCS) program are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal rules and regulations. Oversight is conducted through licensure and regulatory compliance and by program monitoring. The Louisiana Department of Health (LDH) Health Standards Section (HSS) staff conducts on-site surveys to assure state licensure and regulatory compliance for the providers they license.

Pursuant to R.S. 40:2120.2, LDH established minimum licensing standards for home and community-based services (HCBS) providers. These licensing provisions contain the core requirements for HCBS providers as well as the module-specific requirements, depending upon the services rendered by the HCBS provider. These regulations are separate and apart from Medicaid standards of participation or any other requirements established by the Medicaid program for reimbursement purposes. HCBS providers must be licensed to provide LT-PCS.

Health Standards Section Surveys

HSS conducts surveys on-site or through administrative desk reviews to assess provider compliance with licensing regulations and other applicable statutes, rules, and regulations via record review, interviews, and observation.

A provider's failure to be in compliance with State licensing standards could result in sanctions, loss of licensure and other department actions, such as the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

On-Site Reviews

The HSS on-site survey of a provider is unannounced to ensure continuing licensure and regulatory compliance.

Personnel Record Review

The Personnel record review may include:

1. A review of personnel files;

2. Review of time sheets;

3. Review of the current organizational chart; and

4. Provider staff interviews to ensure that direct service workers (DSWs) and supervisors meet staff qualifications in accordance with licensing regulations.

Interviews

As part of the on-site review, HSS staff may interview:

1. A representative sample of the beneficiaries served by the provider;

2. Members of the beneficiary's network of support, which may include family and friends;

3. Direct care staff; and

4. Other members of the beneficiary's community. This may include other employees of the HCBS provider.

This interview process is to assess the overall satisfaction of beneficiaries regarding the provider's performance and to determine the presence of the personal outcomes of the beneficiary in accordance with the plan of care (POC).

Beneficiary Record Review

Following the interviews, HSS staff may review the case records of a representative sample of beneficiaries served. The records will be reviewed to ensure that the activities of the provider are associated with the appropriate services of intake, ongoing assessment, care planning, and transition/closure.

Recorded documentation is reviewed to ensure that the services provided were:

1. Identified in the POC and Individualized Service Plan (ISP) (if applicable);

2. Provided to the beneficiary; and

3. Documented properly.

HSS staff may review the support coordination and professional assessments/re-assessment documentation, service plans, progress notes and other pertinent information in the beneficiary record necessary and required for the survey process.

Report of Survey Findings

Upon completion of the on-site survey, HSS staff discusses the preliminary findings of the survey in an exit interview with appropriate provider staff. HSS staff compiles and analyzes all data collected in the survey, and a written report summarizing the survey findings and a notice for required corrective action, if applicable, is sent to the provider.

The review report includes:

1. A statement of compliance with all applicable regulations; or

2. Deficiencies requiring corrective action by the provider.

HSS program managers may review the survey findings and assess any sanctions, as appropriate.

Corrective Action Report

The provider is required to submit a plan of correction to HSS within 10 working days of receipt of the survey findings.

This plan must address how each cited deficiency has been corrected and how recurrences will be prevented. The provider is afforded one opportunity to dispute the HSS survey findings.

Upon receipt of the written plan of correction, HSS program managers review the provider's plan to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the HSS program manager responds to the provider, requesting resolution of those deficiencies in question.

A follow-up survey may be conducted when deficiencies have been found to ensure that the provider has implemented the plan of correction. Follow up surveys may be conducted on-site or conducted by evidence review.

Informal Dispute Resolution

Providers are afforded one opportunity to dispute the deficiencies cited as a result of a survey. The provider is notified of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider. In order to request the informal hearing, the provider may contact the informal dispute resolution (IDR) program manager at HSS. (See Appendix A for contact information).

The provider is notified of time and place where the informal hearing will be held. The provider may bring any supporting documentation that is to be submitted for consideration.

The HSS staff conducts the informal hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the survey findings. The provider representatives are advised of the date that a written response will be sent and are reminded of the right to a formal appeal, if applicable.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) OVERVIEW

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) established a program that provides Personal Care Services (PCS) to beneficiaries up to age 21 years meeting medically necessary criteria for these services. For purposes of this manual hereafter, the services offered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - PCS program are provided by a Medicaid enrolled agency that has a valid Home and Community Based Services (HCBS) - Personal Care Attendant (PCA) Module License issued by LDH.

The EPSDT – PCS program, by definition, does not include any medical tasks such as medication administration, tracheostomy care, feeding tubes, or catheters. If such tasks are necessary, they must be requested under either the Home Health program or, if the beneficiary is certified for HCBS, through the waiver program. BHSF will not accept the physician's delegation for EPSDT – PCS providers to perform such medical tasks.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) COVERED SERVICES

Personal care services (PCSs) are defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)-PCS include the following tasks:

1. Basic personal care, including toileting, grooming, bathing, and assistance with dressing;

2. Assistance with bladder and/or bowel requirements or problems, including helping the beneficiary to and from the bathroom or assisting the beneficiary with bedpan routines, but excluding catheterization;

3. Assistance with eating and food, nutrition, and diet activities, including preparation of meals for the beneficiary only;

4. Performance of incidental household services, only for the beneficiary, not the entire household, which are essential to the beneficiary's health and comfort in their home. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the beneficiary. Examples of such activities are:

    a. Changing and washing the beneficiary's soiled bed linens;

    b. Rearranging furniture to enable the beneficiary to move about more easily in their own home; and

    c. Cleaning the beneficiary's eating area after completion of the meal and/or cleaning items used in preparing the meal, for the beneficiary only.

5. Remind/prompt an EPSDT eligible beneficiary who is over 18 years of age about self-administered medication;

6. Accompanying, not transporting, the beneficiary to and from their physician and/or medical appointments for necessary medical services;

7. Assisting the beneficiary with locomotion in their place of service, while in bed or from one surface to another; and

8. Assisting the beneficiary with transferring and bed mobility.

The following are not appropriate for personal care and are not reimbursable as EPSDT–PCS:

1. EPSDT–PCS shall not be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian;

2. EPSDT–PCS shall not be used to provide respite care for the primary caregiver; and

3. EPSDT–PCS provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or shall be provided by the Department of Education.

Location of Service

EPSDT–PCS shall be provided in the beneficiary's home, or if medically necessary, in another location outside of the beneficiary's home. The beneficiary's own home includes the following:

1. An apartment;

2. A custodial relative's home;

3. A boarding home;

4. A foster home; or

5. A supervised living facility.

Institutions such as hospitals, institutions for mental disease, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, (ICF/IID) and residential treatment centers are not considered a beneficiary's home.

Service Limitations

EPSDT–PCS are not subject to service limits. The units of service approved shall be based on the physical requirements of the beneficiary and medical necessity for the covered services.

Hours may not be "saved" to be used later or in excess of the number of hours specified according to the approval letter.

Excluded Services

The following services are not appropriate for personal care and are not reimbursable as EPSDT–PCS:

1. Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed);

2. Irrigation of any body cavities which require sterile procedures;

3. Application of dressing, involving prescription medication and aseptic techniques; including care of mild, moderate or severe skin problems;

4. Administration of intradermal, subcutaneous, intramuscular or intravenous injections;

5. Administration of medicine;

6. Cleaning of the home in an area not occupied by the beneficiary;

7. Laundry, other than that incidental to the care of the beneficiary. For example, laundering of clothing and bedding for the entire household as opposed to simple laundering of the beneficiary's clothing or bedding;

8. Skilled nursing services as defined in the state Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;

9. Teaching a family member or friend how to care for a beneficiary who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;

10. Specialized nursing procedures such as:

    a. Insertion of nasogastric feeding tube;

    b. In-dwelling catheter;

    c. Tracheotomy care;

    d. Colostomy care;

    e. Ileostomy care;

f. Venipuncture; and

g. Injections.

11. Rehabilitative services such as those administered by a physical therapist;

12. Teaching a family member or friend techniques for providing specific care;

13. Palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions;

14. Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;

15. Specialized aide procedures such as:

a. Rehabilitation of the beneficiary (exercise or performance of simple procedures as an extension of physical therapy services);

b. Measuring/recording the beneficiary's vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids;

c. Specimen collection; and

d. Special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas.

16. Home IV therapy;

17. Custodial care or provision of only instrumental activities of daily living (ADL) tasks or provision of only one ADL task;

18. Occupational therapy;

19. Speech pathology services;

20. Audiology services;

21. Respiratory therapy;

22. Personal comfort items;

23. Durable medical equipment (DME);

24. Oxygen;

25. Orthotic appliances or prosthetic devices;

26. Drugs provided through the Louisiana Medicaid pharmacy program;

27. Laboratory services; and

28. Social work visits.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) BENEFICIARY CRITERIA

Conditions for provisions of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Services (PCS) are as follows:

1. **Medicaid Eligibility:** The person must be a categorically eligible Medicaid beneficiary, birth through 20 years of age (EPSDT eligible) and have been prescribed medically necessary, age appropriate EPSDT-PCS by a practitioner (physician, advance practice nurse, or physician assistant. The practitioner shall specify the health/medical condition that necessitates EPSDT-PCS;

2. **Medical Necessity:** An EPSDT eligible shall meet medical necessity criteria as established by the Bureau of Health Services Financing (BHSF), which shall be based on functional and medical eligibility and impairment in at least 2 activities of daily living (ADL), as determined by BHSF or its designee. To establish medical necessity, the EPSDT eligible must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if not for being disabled due to illness or injury; and

3. **Practitioner Referral:** EPSDT–PCS shall be prescribed by the beneficiary's attending practitioner initially, every 180 days after that (or rolling 6 months), and when changes in the Plan of Care (POC) occur. The POC shall be acceptable for submission to BHSF only after the practitioner signs and dates the completed form. The practitioner's signature must be an original signature and not a rubber stamp.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) RIGHTS AND RESPONSIBILITIES

The beneficiary shall be allowed the freedom of choice (FOC) to select an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Personal Care Services (PCS) provider. This freedom also extends to the beneficiary's right to change providers at any time should they find it necessary to cease the relationship with the current provider.

Beneficiaries may contact the Bureau of Health Services Financing (BHSF) directly for assistance in locating an EPSDT – PCS provider to submit a prior authorization (PA) request for medically necessary PCS. (See Appendix H for Contact Information).

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) PRIOR AUTHORIZATION

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Services (PCS) are subject to prior authorization (PA) by the Bureau of Health Services Financing (BHSF) or its designee. Services shall not be authorized for more than a 6 month period. A face-to-face medical assessment shall be completed by the practitioner. The beneficiary's choice of a PCS provider may assist the practitioner in developing a plan of care (POC) which shall be submitted for review/approval by BHSF or its designee. Beneficiaries may contact the BHSF directly for assistance in locating a provider to submit a PA request for medically necessary PCS. (See Appendix H for Contact Information).

Initial and Subsequent Prior Authorization Requests

All initial and subsequent PA requests for EPSDT – PCS shall be accompanied by the following documents:

1. Copy of the beneficiary's Medicaid eligibility card;

2. Practitioner's referral for PCS:

    a. EPSDT – PCS **shall be prescribed** by the beneficiary's attending practitioner initially and every 180 days after that (or rolling 6 months), and when changes in the POC occur. The prescription does not have to specify the number of hours being requested, but shall specify PCS and not Personal Care Attendant (PCA);

    b. The practitioner's signature shall be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted; and

    c. Signatures by registered nurses (RNs) on the referrals are not acceptable.

3. POC prepared by the PCS agency with practitioner's approval. The provider may not initiate services or changes in services under the POC prior to approval by BHSF;

4. EPSDT – PCS Form 90:

    a. Completed by the attending practitioner;

b. Completed within the last 90 days;

c. Documents the beneficiary requires assistance with at least 2 activities of daily living (ADL); and

d. Documents a face-to-face medical assessment was completed.

5. EPSDT – PCS - Daily Schedule Form;

6. EPSDT - PCS - Social Assessment Form;

7. Request for PA Form (PA-14); and

8. Other documentation that would support medical necessity (i.e., other independent evaluations).

Information about forms used with a PA request can be found in Appendix I.

Requests for prior approval of EPSDT –PCS should be submitted by fax or electronically (e-PA) to the PA Unit. (See Appendix H for Contact Information).

The request shall be reviewed by BHSF's physician consultant and a decision rendered as to the approval of the service. A letter will be sent to the beneficiary, the provider and the support coordination agency (SCA), if available, advising of the decision.

Chronic Needs Case

Beneficiaries who have been designated by BHSF as a "Chronic Needs Case" are exempt from the standard PA process. A new request for PA shall still be submitted every 180 days; however, the EPSDT-PCS provider shall only be required to submit a PA-14 form accompanied by a statement from the beneficiary's primary practitioner verifying that the beneficiary's condition has not improved and the services currently approved must be continued. The provider shall indicate "Chronic Needs Case" on the top of the PA-14 form. This determination only applies to the services approved where requested services remain at the approved level.

Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request.

NOTE: Only BHSF or its designee will be allowed to grant the designation of a "chronic needs case" to a beneficiary.

Plan of Care

The POC shall be written on the current version of the EPSDT-PCS POC – 1 Form which can be downloaded from the Louisiana Medicaid website. (See Appendix I for Forms and Links). The form shall be completed in its entirety and shall specify the personal care task(s) to be provided (i.e., ADL for which assistance is needed) and the frequency and duration required to complete each of these tasks.

Dates of service not included in the POC or services provided before approval of the POC by BHSF or its designee, are not reimbursable.

The beneficiary's attending practitioner shall review and/or modify the POC and sign and date it prior to the POC being submitted to BHSF or its designee.

The POC shall include the following information:

1. Beneficiary name, Medicaid ID number, date of birth (DOB), address, and phone number;
2. Date EPSDT-PCS are requested to start;
3. Provider name, Medicaid provider number and address of personal care agency;
4. Name and phone number of someone from the provider agency that may be contacted, if necessary, for additional information;
5. Medical reasons supporting the beneficiary's need for PCS;
6. Other in-home services the beneficiary is receiving;
7. Specific personal care tasks (bathing, dressing, eating, etc.) with which PCS provider is to assist the beneficiary;
8. Goals for each activity;
9. Number of days services are required each week;
10. Time requested to complete each activity;
11. Total time requested to complete each activity each week; and
12. Signature of parent/primary caregiver, provider representative and the beneficiary's primary practitioner.

Changes in Plan of Care

Revisions to the POC shall be submitted as they occur and shall be treated as a new POC which begins a new 6 month service period. Revisions to the POC may be necessary because of changes that occur in the beneficiary's medical condition which warrant an additional type of service, change in frequency of service, or an increase or decrease in duration of service.

Documentation required for a revised POC is the same as for a new POC. Both a new "start date" and "reassessment date" shall be established at the time of reassessment. The EPSDT-PCS provider may not initiate services, or changes in services, under the POC prior to approval by BHSF or its designee.

Subsequent Plans of Care

A new POC shall be submitted at least every 180 days (rolling 6 months). The subsequent POC shall:

1. Be approved by the beneficiary's attending practitioner;

2. Reassess the beneficiary's need for EPSDT–PCS;

3. Include any updates to information which has changed since the previous assessment was conducted; and

4. Explain when and why the change(s) occurred.

The POC shall be acceptable only after the practitioner signs and dates the completed form. The practitioner's signature shall be an original signature and not a rubber stamp.

Reconsideration Requests

If the PA request is not approved as requested, the provider may submit a request for a reconsideration of the previous decision. When submitting a reconsideration request, providers should include the following:

1. A copy of the PA notice with the word "Recon" written across the top and include the reason the reconsideration is being requested written across the bottom;

2. All original documentation submitted from the original request; and

3. Any additional information or documentation which supports medical necessity.

The reconsideration request packet should be sent to the PA Unit via fax or e-PA. After the reconsideration request has been reviewed, a new notification letter with the same PA number will be generated and mailed to the provider, beneficiary, and support coordinator, if the beneficiary has a case manager.

Changing PCS Providers

Beneficiaries have the right to change providers at any time; however, approved authorizations are not transferred between agencies. If a beneficiary elects to change providers within an authorization period, the current agency shall notify the Prior Authorization Unit (PAU) of the beneficiary's discharge, and the new agency shall obtain their own authorization through the usual authorization process.

Beneficiaries may contact the BHSF directly for assistance in locating another provider.

Prior Authorization Liaison

The Prior Authorization Liaison (PAL) was established to facilitate the authorization process for EPSDT beneficiaries who are part of the Request for Services Registry. The PAL assists by contacting the provider, beneficiary, and support coordinator (if the beneficiary has one) when a request cannot be approved by the PAU because of a lack of documentation or a technical error.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) PROVIDER REQUIREMENTS

Standards of Participation

Personal Care Services (PCS) must be provided by a licensed PCS agency that is duly enrolled as a Medicaid provider. Agencies providing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)–PCS shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by federal, state and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, Occupational Safety and Health Administration (OSHA) requirements, liability insurance, Worker's Compensation, occupational licenses, etc. Agencies shall comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

EPSDT–PCS shall only be provided to EPSDT beneficiaries and only by a staff member of a licensed personal care attendant (PCA) agency enrolled as a Medicaid PCS provider.

A copy of the current PCA license must accompany the Medicaid application for enrollment as a PCS provider.

Copies of current licenses shall be submitted to Louisiana Medicaid Provider Enrollment thereafter, as they are issued for inclusion in the enrollment record. The provider's enrollment record shall include a current PCA license at all times.

PCS shall be authorized only when provided by a licensed PCS agency which is duly enrolled as a Louisiana Medicaid provider and certain out-of-state providers located only in the trade areas of Arkansas, Mississippi, and Texas.

Provider agencies shall comply with the policies and procedures contained in the PCS provider manual for the EPSDT–PCS program.

Electronic Visit Verification

The agency shall use an electronic visit verification (EVV) system for time and attendance tracking and billing for EPSDT-PCS.

EPSDT-PCS providers identified by Bureau of Health Services Financing (BHSF) shall use the following:

1. The EVV system designated by the Department; or

2. An alternate system that has successfully passed the data integration process to connect to the designated EVV system, and is approved by the Department.

Reimbursement for services may be withheld or denied if an EPSDT-PCS provider fails to use the EVV system, or uses the system not in compliance with Medicaid's policies and procedures for EVV.

Staffing

The licensed PCS agency is responsible for ensuring that all direct service workers (DSWs) providing EPSDT-PCS meet all training requirements applicable under state law and regulations.

Individuals who provide coverage in the PCS worker's absence must meet all staffing requirements for the PCS worker or supervisor.

Providers must conduct criminal background checks on the direct care and supervisory staff. A worker may be assigned to provide services to a beneficiary prior to the results of the criminal background check under the direct supervision of a permanent employee or in the presence of a member of the immediate family of the beneficiary or a caregiver designated by the immediate family of the beneficiary as outlined in R.S. 40:1300.52(C)(2). If the results of any criminal background check reveal that the employee was convicted of any offenses as described in R.S. 40:1300.53, pursuant to the statutory revision authority of the Louisiana State law institute, the employer shall not hire or may terminate the employment of such person.

EPSDT-PCS services shall be provided by an individual who meets the following qualifications:

1. Must be at least 18 years of age at the time the offer of employment is made;

2. Must have the ability to read and write in English, and to carry out directions promptly and accurately; and

3. Must pass a criminal background check.

The following persons are prohibited from serving as the DSW for the beneficiary:

1. Father;

2. Mother;

3. Sister/brother;

4. In-law;

5. Grandparent;

6. Curator;

7. Tutor;

8. Legal guardian;

9. Beneficiary's responsible representative; or

10. Person to whom the beneficiary has given representative and mandate authority (Power of Attorney).

The PCS may be provided by a person of a degree of relationship to the beneficiary other than immediate family, only if the relative is not living in the beneficiary's home, or, if they are living in the beneficiary's home solely because their presence in the home is necessitated by the amount of care required by the beneficiary.

If the provider proposes **involuntary transfer, discharge of a beneficiary, or if a provider closes** in accordance with licensing standards, the following steps must be taken:

1. The provider shall give written notice to the beneficiary and the responsible representative, if known, at least 30 calendar days prior to the transfer or the discharge;

2. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the beneficiary understands;

3. A copy of the written discharge/transfer notice shall be put in the beneficiary's record; and

4. When the safety or health of beneficiaries or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge.

The written notice shall include the following:

1. A reason for the transfer or discharge;

2. The effective date of the transfer or discharge;

3. An explanation of a beneficiary's right to personal and/or third party representation at all stages of the transfer or discharge process;

4. Contact information for Disability Rights Louisiana;

5. Names of provider personnel available to assist the beneficiary and family in decision-making and transfer arrangements;

6. The date, time and place for the discharge planning conference;

7. A statement regarding the beneficiary's appeal rights;

8. The name of the director, current address and telephone number of the Division of Administrative Law (DAL); and

9. A statement regarding the beneficiary's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

1. Holding a transfer or discharge planning conference with the beneficiary, legal representative, support coordinator (if applicable), and advocate, if such is known;

2. Developing discharge options that will provide reasonable assurance that the beneficiary will be transferred or discharge to a setting that can be expected to meet their needs;

3. Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the beneficiary; and

4. Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

NOTE: The requirements above do not apply when the beneficiary is being discharged from the EPSDT-PCS program by the Louisiana Department of Health (LDH).

Failure of the provider to meet the minimum standards shall result in a range of required corrective actions including, but not limited to, the following:

1. Removal from the Freedom of Choice (FOC) listing;

2. A citation of deficient practice;

3. A request for corrective action plan; and/or

4. Administrative sanctions.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) SERVICE DELIVERY

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – Personal Care Services (PCS) providers may not provide services at the same time as other covered services, unless medically necessary.

Medicaid prohibits multiple professional disciplines from being present in the beneficiary's residential setting at the same time. However, multiple professionals may provide services to multiple beneficiaries in the same residential setting when it is medically necessary. This includes but is not limited to nurses, home health aides, and therapists. The Bureau of Health Services Financing (BHSF) or its designee will determine medical necessity for fee-for-service (FFS) beneficiaries.

Children's Choice (CC) waiver services and PCS may be performed on the same date, but not at the same time. If the beneficiary is receiving home health, respite, and/or any other related service, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider.

Beneficiaries who receive EPSDT – PCS may also receive hospice services on the same date, but not at the same time. The hospice provider and the PCS provider must coordinate services and develop the patient's plan of care (POC).

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS)
RECORD KEEPING

Providers must maintain case records for all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Service (PCS) beneficiaries and personnel records on all supervisory and direct care staff. Records must be complete, accurately documented, readily accessible, and organized. All records must be retained for a period of 6 years. Billing records must be maintained for a period of 6 years from the date of payment.

Any error made in a beneficiary's or employee's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. Correction fluid must never be used in a beneficiary's or employee's record.

There shall be a clear audit trail between the:

1. Prescribing practitioner;
2. PCSs provider agency;
3. Person providing the PCS to the beneficiary; and
4. Services provided and reimbursed by Medicaid.

Beneficiary Records

Providers must provide reasonable protection for beneficiary records against loss, damage, destruction, and unauthorized use. A provider must have a separate written record for each beneficiary that includes:

1. Copies of all plans of care (POC), social assessments, EPSDT-PCS Form 90, EPSDT–PCS daily schedule forms, and practitioners order/prescription for EPSDT-PCS;
2. Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying the POC including the tests performed and results, copies of evaluation and diagnostic assessment reports signed by the individual performing the test and/or interpreting the results;
3. Documentation of approval of services by the Bureau of Health Services Financing (BHSF) or its designee; and

4. Documentation of the provision of services by the PCS worker including signed daily notes by the worker, and supervisor if appropriate, that include the following:

   a. Date of service;

   b. Services provided (checklist is adequate);

   c. Total number of hours worked;

   d. Time period worked;

   e. Condition of beneficiary;

   f. Service provision difficulties;

   g. Justification for not providing scheduled services; and

   h. Any other pertinent information.

Availability of Records

Providers must make beneficiary and personnel records available to the Louisiana Department of Health (LDH), its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for LDH or its designee.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) REIMBURSEMENT

All claims for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Services (PCS) shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. Providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier. Refer to Appendix C for information about procedure code, unit of service and the current reimbursement rate. EPSDT – PCS shall be paid the lesser of billed charges or the maximum unit rate set by the Bureau of Health Services Financing (BHSF).

Current procedure codes must be used to identify services. Time units shall be those defined by the current procedure code, not including travel time. The entire time submitted must be spent providing services to the beneficiary. Units of service approved shall be based on the physical or cognitive limitations of the beneficiary and medical necessity for the covered services in the EPSDT-PCS program.

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

If the claim for EPSDT – PCS is submitted without the prior authorization (PA) number, the claim will automatically deny with the error code "191" (Procedure Requires PA).

If the dates of services on the claim are not within the dates in the PA, the claim will be denied with error code "193" (Date on Claim Not Covered by PA).

If an incorrect number of units are billed, the claim will be denied with error code "194" (Claim Exceeds PA Limits).

Hours may not be "saved" to be used later or in excess of the number of hours specified in the approval letter.

Hardcopy claims must be mailed to the fiscal intermediary (FI). (See Appendix H for Contact Information).

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) FORMS, DOCUMENTS, AND LINKS

The following documents, forms, links and manuals are available on the following website addresses:

Form/Document/Website Name	Website Address
Health Standards Section (HSS) Direct Service Worker (DSW) Guidelines	http://www.ldh.la.gov/index.cfm/page/3779
Long-Term - Personal Care Services (LT-PCS) Service Log	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/LT-PCSServiceLogAndInstructions.pdf
Release of Confidentiality for Shared Personal Assistance Services (PAS) or LT-PCS	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/Confidentiality-Consent-Shared-Services.pdf
LT-PCS: DSW/Participant Relationship and Living Arrangements Guidance	https://ldh.la.gov/assets/docs/OAAS/LTPCSDocuments/OAAS-PC-24-001-LT-PCS-DSW-Participant-Relationship-and-Living-Arrangements-Guidance-RI-6-25-24.pdf
Rights and Responsibilities for LT-PCS Applicants/Participants	http://www.ldh.la.gov/assets/docs/OAAS/publications/RightsRespon_LTPCS.pdf
Electronic Visit Verification (EVV)	http://ldh.la.gov/index.cfm/page/2751

Louisiana State Adverse Actions List Search Database	https://adverseactions.ldh.la.gov/SelSearch
Office of the Inspector General (OIG) List of Excluded Individuals Database	https://exclusions.oig.hhs.gov/
Federal System Award Management	https://sam.gov/content/home
Medicaid Services Chart	http://www.ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf
LT-PCS State Plan Amendment	Attachment 3.1-A Item 26 Personal Care Services (la.gov)
LT-PCS Rule– LAC Title 50: Part XV. Subpart 9. PCSs	https://www.doa.la.gov/media/vs3btetk/50.pdf
Home and Community Based Services (HCBS) Providers Licensing Rule– LAC Title 48: Part I. Subpart 3. Chapter 50. HCBS Providers Licensing Standards	https://www.doa.la.gov/media/15odwaqn/48v01.pdf

LONG-TERM – PERSONAL CARE SERVICES (LT-PCS) CONTACT INFORMATION

Name of Office/Entity	Type of Assistance	Contact Information
Conduent (Access Contractor)	Office to send signed "Agreement to Provide Services" and who to contact when requesting Long-Term-Personal Care Services (LT-PCS)	Long Term Care (LTC) Access Services 2900 Westfork Drive, Suite 540 Baton Rouge, LA 70827 Phone #: 877-456-1146 TDD #: 877-544-9544 Fax #: 866-246-8511
Office of Aging and Adult Services (OAAS) State Office	Provides LT-PCS policy clarification and receives complaints regarding the LTC services access contractor	Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031 Phone #: 1-866-758-5035 Fax #: 225-219-0202
OAAS Help Line	Requests for approval from OAAS when planning a trip/traveling out of state (and within the U.S.) while receiving LT-PCS	OAAS.Inquiries@la.gov
OAAS Provider Relations	Receives questions from providers and reviews additional benefits for approval regarding wage and non-wage benefit requirements	OAAS.ProviderRelations@la.gov
OAAS Regional Offices	Reviews and provides approval of waiver services (including Adult Day Health Care (ADHC) Waiver with LT-PCS) and offers providers technical assistance	http://new.dhh.louisiana.gov/index.cfm/directory/category/141
Gainwell Provider Enrollment Unit	Office to contact to report changes in provider ownership, address, telephone number or account information affection electronic funds transfer	Gainwell Provider Enrollment Unit P.O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 or (225) 924-5040 http:///www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm

Gainwell Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information and billing issues	Gainwell Provider Relations Unit P.O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040 http:///www.lamedicaid.com/provweb1/Provider_Support/provider_support index.htm
Statistical Resources, Inc.	Agency to contact regarding Louisiana State Reporting System (LaSRS), electronic visit verification (EV), and prior authorization (PA) Billing Issues	11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501 Fax#: (225) 767-0502
Division of Administrative Law (DAL) - Louisiana Department of Health (LDH) Section	Office to contact to request an appeal hearing	Division of Administrative Law – LDH Section Post Office Box 4189 Baton Rouge, LA 70821-4189 Physical: 1020 Florida Street Baton Rouge, LA 70802 Phone #: (225) 342-5800 Fax #: (225) 219-9823 https://www.adminlaw.state.la.us/
LDH - Health Standards Section (HSS)	Office to contact to report changes that affect provider license (e.g. address change, change of ownership, etc.) Office to contact when providers wish to request an informal hearing as the result of a provider's receipt of a statement of deficient practice or file a complaint against a provider by a beneficiary	Health Standards Section P. O. Box 3767 Baton Rouge, LA 70821 Phone #: 1-800-660-0488

Medicaid Program Integrity	Office to contact to report Medicaid fraud	Provider Fraud Hotline #: 1-800-488-2917 Beneficiary Fraud Hotline #: 1-888-342-6207 Provider Fraud Fax #: (225) 216-6129 Beneficiary Fraud Fax #: (225) 389-2610 http://new.dhh.louisiana.gov/index.cfm/page/219
Adult Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors	1-800-898-4910
Elderly Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older	1-833-577-6532
Myers and Stauffer LC	Information about filing cost reports	http://www.mslc.com/Louisiana/HCBS.aspx

BILLING CODES

All personal care services (PCS) must be prior authorized and billed using the appropriate provider number that was issued for PCS.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Information on procedure codes and the current rates is available at: EPSDT_PCS_FS.pdf (lamedicaid.com)

Long Term – Personal Care Services (LT-PCS)

Information on procedure codes and the current rates is available at:
https://www.lamedicaid.com/provweb1/fee_schedules/LTPCSServiceCodeRateChart.pdf

DATABASE CHECKS

Providers must screen potential and active employees using the following databases:

1. **Louisiana State Adverse Actions List; and**
2. **Office of Inspector General (OIG) List of Excluded Individuals.**

Potential employees must be screened for any exclusions **AND** adverse actions **upon hire**.

All employees must be screened **MONTHLY** using the above databases.

Providers **MUST** retain the database checks' print outs/documents as documentation that these checks were completed upon hire and monthly thereafter.

CNA Lookup Database

The provider will:

1. Go to https://tlc.dhh.la.gov/frmsearchweb2.aspx; and
2. Check for potential employees/employees:
    a. Type in the potential employee/employee's first name, middle name, social security number (SSN) (if known) and date of birth (DOB); and
    b. Click on the search button to bring up existing records.

Louisiana State Adverse Actions List Search Database

The provider will:

1. Go to https://adverseactions.ldh.la.gov/selsearch; and
2. Check for potential employees/employees:
    a. Type in the potential employee/employee's SSN, name and/or any other names that the individual typically goes by (if applicable); and
    b. Click on the search button to bring up existing records.

Office of Inspector General List of Excluded Individuals Database

The provider will:

1. Go to https://exclusions.oig.hhs.gov/; and
2. Check for potential employees/employees:
    a. Type in the potential employee/employee's name and/or any other names that the individual typically goes by (if applicable);
    b. Click on the search button to bring up existing records;
    c. If a record with the potential employee/employee's name is found, click verify; and
    d. Enter the SSN to verify the match.

What to do with the results of these checks?
For all of the databases stated above, if no results are found, this individual is not currently excluded and may begin/continue employment with your agency. **Regardless of the database results, the provider MUST keep documentation as proof that these searches were conducted.** If the potential employee/employee's name appears on one of the databases listed above, you **CANNOT**: 1. Hire that individual as an employee; and/or 2. Allow the employee to continue working for your agency.

WAGE AND NON-WAGE BENEFITS

The following wage and non-wage benefits have been authorized by the Louisiana Department of Health (LDH) and the Office of Aging and Adult Services (OAAS):

1. Increased wages above the minimum wage floor of $9.00 per hour, to include the increased (ONLY) employer associated costs for (payroll taxes, liability and workers compensation insurance, 401K or retirement savings);

2. Bonuses (sign-on, recruitment and retention bonuses);

3. Paid vacation leave;

4. Personal Protective Equipment (PPE);

5. Paid sick leave;

6. Gas mileage reimbursement;

7. Training;

8. Employer paid/supplemented health care insurance; and/or

9. Uniforms for direct support workers and increased (ONLY) employer associated costs.

Any additional benefits not listed above **MUST** be **pre-approved by OAAS** before the benefit is added to the provider's policy, or, prior to being provided to the direct service worker (DSW). Providers must email their proposed additional benefits to OAAS at OAAS.ProviderRelations@la.gov. OAAS will respond to the provider within 10 business days from the date of the submitted email.

NOTE: OAAS does NOT need to approve the provider's policy pertaining to the wage and non-wage benefit requirements. Providers must ONLY send their requests to OAAS if they would like to use other benefits that are not listed above.

AUDITS FOR WAGE FLOOR AND WAGE AND NON-WAGE BENEFITS

Long-Term – Personal Care Services (LT-PCS) providers may be audited by the Louisiana Department of Health (LDH) or its designee to ensure compliance with wage floor and wage and non-wage benefit requirements. These providers must provide all requested documentation within the deadline identified. Documentation may include, but is not limited to the following:

1. Payroll records;

2. Wage and salary sheets;

3. Check stubs; and

4. Copies of unemployment insurance files; etc.

LT-PCS providers must provide the requested documentation within the timeline provided by LDH.

Non-compliance or failure to demonstrate that the wage floor and wage and non-wage benefits were paid directly to direct service workers (DSWs) may result in the following:

1. Sanctions/penalties; or

2. Disenrollment from the Medicaid program.

LT-PCS providers will be subject to sanctions or penalties for failure to comply with any aspect of the wage floor and wage and non-wage benefits requirements. The severity of such action will depend on the following factors:

1. Failure to pass 70% of the LT-PCS provider rate increases directly to the DSWs in the form of a floor minimum of $9.00 per hour and in other wage and non-wage benefits;

2. The number of employees identified that the LT-PCS provider has not passed 70% of the provider rate increases directly to the DSWs in the form of a floor minimum of $9.00 per hour and in other wage and non-wage benefits;

3. The persistent failure to not pass 70% of the LT-PCS provider rate increases directly to the DSWs in the form of a floor minimum of $9.00 per hour and in other wage and non-wage benefits; and

4. Failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with the wage floor and wage and non-wage benefits requirements.

GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Personal Care Services (PCS) Manual Chapter for long-term – personal care services (LT-PCS) and Early and Periodic Screening Diagnostic and Treatment (EPSDT) – PCS.

Abuse - The infliction of physical and mental injury, or actions which may reasonably be expected to inflict physical injury, on an adult by other parties, including, but not limited to such means as: sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. (La R.S. 15:1503)

Abuse of Medicaid Funds – Inappropriate use of public funds by either providers or beneficiaries, including practices which are not criminal acts and may even be technically legal; however, represent the inappropriate use of public funds.

Activities of Daily Living (ADL) - The functions or basic self-care tasks that an individual performs in a typical day, independently or with supervision/assistance. ADL include bathing, dressing, eating, grooming, walking, transferring and/or toileting. The extent to which a person requires assistance to perform one or more of these activities often is a level of care (LOC) criterion.

Adult Day Health Care (ADHC) Waiver – An optional Medicaid program under section 1915(c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who meet nursing facility level of care (NFLOC) requirements and are age 65 or older, or aged 22-64 and have a physical disability.

Adult Protective Services (APS) - The office within Office of Aging and Adult Services (OAAS) that handles reports of suspected cases of abuse, neglect, exploitation or extortion of emancipated minors and adults ages 18-59.

Advocacy – The process of assuring that beneficiaries receive appropriate, high quality supports and services and locating additional services not readily available in the community.

Agreement to Provide Services - An agreement between the LT-PCS provider and the LT-PCS beneficiary. The agreement specifies responsibilities with respect to the provision of services.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination. (See Fair Hearing).

Approval Date – The date the plan of care (POC) is approved.

Applicant – An individual who is requesting Medicaid services (LT-PCS or EPSDT-PCS).

Assessment – One or more processes that are used to obtain information about a person, including: their condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person meets NFLOC and requirements of the LT-PCS program. The results are used to develop the POC and an Individualized Service Plan (ISP).

Beneficiary – An individual who has been certified for PCS through the Medicaid program. A beneficiary may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) - The bureau within the Louisiana Department of Health (LDH) that is responsible for the administration of the Medicaid program.

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Certification Period – The time period that a LT-PCS beneficiary is qualified to receive services.

Chronic Needs Case – A designation granted to some EPSDT–PCS beneficiaries by the Prior Authorization Unit (PAU) when the beneficiary's medical condition is such that services are expected to be continuous and remain at the level currently approved.

Community Choices Waiver (CCW) – An optional Medicaid program under section 1915(c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who meet NF LOC requirements and are age 65 or older, or aged 21–64 and have a physical disability.

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

Corrective Action Plan –A provider's written description of action required to correct identified deficiencies.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid and other public health programs.

Direct Care Staff – Unlicensed staff who have face-to-face contact with and are paid to provide personal care and other direct service and support to qualified beneficiaries to enhance their well-being.

Elderly Protective Services (EPS) - The office within the Governor's Office of Elderly Affairs that handles reports of suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older.

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to beneficiaries. The EVV system will ensure that LT-PCS beneficiaries are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Eligibility – The determination that a beneficiary qualifies to receive services based on meeting established criteria as set by LDH.

Enrollment –The determination, made by LDH, that a provider meets the necessary requirements to participate as a Medicaid provider. This is also referred to as provider enrollment or certification.

Exploitation – The illegal or improper use or management of the funds, assets or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage (La. R.S. 15:1503).

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority (La. R.S. 15:1503).

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Medicaid's comprehensive and preventive child health program for individuals who are under the age of 21.

Fair Hearing – A legal proceeding in which the beneficiary and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer.

Fiscal Intermediary (FI) – The contractor, managed by the Medicaid Management Information System (MMIS), which processes claims, issues payments to providers, handles provider inquiries and complaints, and provides training for providers.

Formal Services – Professional and paid services.

Good Cause – An acceptable reason to change providers outside of the designated circumstances and timelines.

Health Standards Section (HSS) – The section of LDH responsible for the licensure and enforcement of compliance of those health care providers licensed by HSS.

Hospice – An alternative treatment approach for a terminally ill patient that focuses on palliative care and support for their family.

Individualized Service Plan (ISP) – An individualized plan of action written and followed by providers to address the beneficiary's difficulties, health care needs, and services based on their assessment. A comprehensive POC prepared in accordance with policies, procedures, and timelines established by Medicaid or by an LDH program office for reimbursement purposes may be substituted for the ISP for in-home providers.

Informal Services –Non-professional and non-paid services provided by family, friends and community/social network.

Institutionalization – The placement of a beneficiary in an inpatient facility, including but not limited to: hospitals, nursing facilities or psychiatric hospitals.

Instrumental Activities of Daily Living (IADL) – Routine household tasks that are considered essential for sustaining the individual's health and safety, but may not require performance on a daily basis.

Intake – The LT-PCS screening process to determine a beneficiary's need and qualification for PCS.

Level of Care Eligibility Tool (LOCET) – An algorithm-based screening tool used by OAAS and/or its designee during the initial intake screening process to determine if an applicant "presumptively" meets NFLOC eligibility criteria.

Licensure – A determination by HSS that a provider meets the requirements of state law to provide health care and services.

Linkage –The act of connecting a beneficiary to a specific provider.

Long-Term Care (LTC) Access Contractor – The contractor responsible for managing the authorization of services for beneficiaries in the LT-PCS program.

Long Term-Personal Care Services (LT-PCS) – An optional Medicaid State Plan service which assists with ADL and IADL as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older, and meet specific program requirements.

Louisiana Department of Health (LDH) – The agency responsible for administering the state's Medicaid program and other health and related services including: aging and adult, public health, mental health, developmental disabilities, and behavioral health.

Louisiana Service Reporting System (LaSRS) – A secure modular web application developed by an LDH contractor to issue prior authorizations (PAs) for LT-PCS and confirm post authorizations through EVV.

Medicaid – A federal-state financed medical assistance program authorized through Title XIX of the Social Security Act and administered under approved State Plan.

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

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Medicare – A health insurance program for the aged and disabled provided under Title XVIII of the Social Security Act.

Neglect – The failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care for their well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall, for that reason alone, be considered to be neglected or abused (La. R.S. 15:1503).

Non-Allowable Costs – Costs that are not based on the reasonable cost of services covered under Medicare/Medicaid and are not related to the care of beneficiaries.

Nursing Facility – A facility which meets the requirements of sections 1819 or 1919(a), (b), (c) and (d) of the Social Security Act. A NF provides intermediate, skilled nursing, and/or LTC for those individuals who meet eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within LDH responsible for the management and oversight of certain Medicaid home and community-based services (HCBS), waiver programs, State Plan programs including LT-PCS, APS for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

OAAS Regional Office – One of 9 administrative offices within OAAS.

Office for Citizens with Developmental Disabilities (OCDD) – The office in LDH responsible for services to individuals with developmental disabilities.

Program of All-Inclusive Care for the Elderly (PACE) – A capitated, managed care program under the Medicaid State Plan that coordinates and provides all needed preventative, primary health, acute and LTC services for enrolled beneficiaries.

Person-Centered – An approach used in the assessment and planning processes that considers a beneficiary's personal experiences and preferences.

Personal Outcome – Result achieved by or for the beneficiary through the provision of services and supports that make a meaningful difference in the quality of the individual's life.

Personal Representative – An individual designated by a Medicaid beneficiary to act on their behalf when applying for and/or receiving Medicaid services.

Plan of Care (POC) – A written, person-centered plan developed by the beneficiary and their authorized representative based on assessment results. This document identifies each service area and outlines how services will be delivered to a beneficiary based on their preferences.

Prior Authorization Liaison (PAL) – Facilitates the prior authorization approval process for EPSDT-PCS beneficiaries who are part of the Request for Services Registry.

Progress Notes – Documentation of the delivery of services, activities, and/or observations of a beneficiary.

Provider – A licensed provider that delivers Medicaid PCS under a provider agreement with LDH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other LDH office that specifies responsibilities with respect to the provision of services and payment under Medicaid or other LDH office.

Provider Enrollment – See "Enrollment".

Re-assessment –The re-assessment is completed at least once every 18 months for LT-PCS beneficiaries and when status changes occur in order to update the POC and/or ISP.

Responsible/Personal Representative – An adult who has been designated by the beneficiary to act on the beneficiary's behalf with respect to their services. The written designation of a responsible representative does not give legal authority for that individual to handle the beneficiary's business without the beneficiary's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Self-neglect – The failure, by either the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care for their own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall, for that reason alone, be considered to be self-neglected (La. R.S. 15:1503).

Service Area – A designated region where services are provided.

Service Period Authorization – The period that a provider is authorized to provide services.

Sexual Abuse – Any non-consensual sexual activity between a beneficiary and another individual. Sexual activity includes, but is not limited to: kissing, hugging, stroking, or fondling with sexual intent, oral sex or sexual intercourse, insertion of objects with sexual intent or request, suggestion, or encouragement by another person for the beneficiary to perform sex with any other person when beneficiary is not capable of or competent to refuse.

Supports Waiver (SW) - A 1915(c) waiver designed to create options and provide meaningful opportunities through vocational and community inclusion for those individuals 18 years of age and older who have a developmental disability.

Transition – A shift from a beneficiary's current services to another appropriate level of services, including discharge from all services.

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

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) CONTACT INFORMATION

Common Questions	Who to Contact	Contact Information
Who can beneficiaries call to request assistance in locating an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Personal Care Services (PCS) provider?	Bureau of Health Services Financing (BHSF)	1-888-758-2220
Where do providers send their prior authorization (PA) requests?	Gainwell Technologies – Prior Authorization Unit (PAU)	Fax: (225) 216-6481 Electronic: www.lamedicaid.com
Where do providers send their claims?	Gainwell Technologies	Gainwell Technologies Electronically at www.lamedicaid.com or P. O. Box 91020 Baton Rouge, LA 70821
Who do providers contact regarding billing problems?	Gainwell Technologies	1-800-473-2783 or (225) 924-5040

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – PERSONAL CARE SERVICES (PCS) FORMS AND LINKS

The following forms are used in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - Personal Care Services (PCS) program and can be downloaded from www.lamedicaid.com at the "Forms/Files/Surveys/User Manuals" link:

1. Request for Prior Authorization (PA) (PA – 14);

2. Request for Medicaid EPSDT – PCS (EPSDT - PCS Form 90);

3. EPSDT - PCS– Plan of Care (POC) (EPSDT - PCS POC – 1);

4. EPSDT - PCS – Social Assessment Form (EPSDT - PCS Social Assessment – 2); and

5. EPSDT - PCS Daily Schedule (EPSDT - PCS Daily Schedule – 3).

CLAIMS RELATED INFORMATION

Hard copy billing of Personal Care Services (PCS) are billed on the Centers for Medicare and Medicaid (CMS)-1500 (02/12) claim form or electronically in the 837P transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required, situational,** or **optional**.

Required information must be entered in order for the claim to process. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

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

Services may be billed using:

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

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

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

This appendix includes the following:

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

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

CMS-1500 (02/12) Billing Instructions for Personal Care Services (PCS)

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	
1a	Insured's Identification (ID) Number	**Required** – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through Medicaid Eligibly Verification System (MEVS), eMEVS, or Recipient Eligibly Verification System (REVS). **NOTE:** The beneficiary's 13-digit Medicaid ID number must be used to bill claims. The claim communication number (CCN) from the plastic ID card is **NOT** acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	**Required** – Enter the beneficiary's last name, first name, middle initial.	
3	Patient's Date of Birth (DOB) Sex	**Required** – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	

Locator #	Description	Instructions	Alerts
4	Insured's Name	**Situational** – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	**Optional** – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	**Situational** – Complete if appropriate or leave blank.	
7	Insured's Address	**Situational** – Complete if appropriate or leave blank.	
8	RESERVED FOR NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) USE	**Leave Blank.**	
9	Other Insured's Name	**Situational** – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	**Leave Blank.**	
9b	RESERVED FOR NUCC USE	**Leave Blank.**	
9c	RESERVED FOR NUCC USE	**Leave Blank.**	
9d	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	**Situational** – Complete if appropriate or leave blank.	
11	Insured's Policy Group or Federal Employees Compensation Act (FECA) Number	**Situational** – Complete if appropriate or leave blank.	

Locator #	Description	Instructions	Alerts
11a	Insured's DOB Sex	**Situational** – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	**Leave Blank**.	
11c	Insurance Plan Name or Program Name	**Situational** – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	**Situational** – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	**Situational** – Complete if appropriate or leave blank.	
13	Patient's or Authorized Person's Signature (Payment)	**Situational** – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	**Optional.**	
15	OTHER DATE	**Leave Blank.**	
16	Dates Patient Unable to Work in Current Occupation	**Leave Blank.**	
17	Name of Referring Provider or Other Source	**Situational –** Complete if applicable. Enter the applicable qualifier to the left of the vertical, dotted line to Identify which provider is being reported. **DK Ordering Provider** In the following circumstances, entering the name (First Name,	**For LA Medicaid other source is defined as the ordering provider.** **Any provider entered as an ordering provider**

Locator #	Description	Instructions	Alerts
		Middle Initial, Last Name) followed by the credentials of the ordering physician or non-physician practitioner and appropriate qualifier is required: **EPSDT–PCS** Services always require an ordering provider	**must be enrolled with LA Medicaid.** **Note: LT-PCS does not require an ordering provider but if no one is listed on the claim, it must be valid.**
17a	Other ID #	**Situational** Complete if applicable. Enter the 7-digit Medicaid ID number of the ordering provider.	**Enter the 7- digit Medicaid ID Number here.**
17b	National Provider Identifier (NPI)#	**Situational –** Complete if applicable. Enter the NPI number of the ordering provider.	**The 10-digit NPI Number is required.**
18	Hospitalization Dates Related to Current Services	**Optional.**	
19	Additional Claim Information (Designated by NUCC)	**Leave Blank.**	
20	Outside Lab? $Charges	**Leave Blank.**	

Locator #	Description	Instructions	Alerts
21	International Classification of Diseases (ICD) Indicator Diagnosis or Nature of Illness or Injury	**Required** -- Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM **Required** -- Enter the most current ICD diagnosis code. **NOTE:** ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as non-primary diagnosis codes	**The most specific diagnosis codes must be used. General codes are not acceptable.**

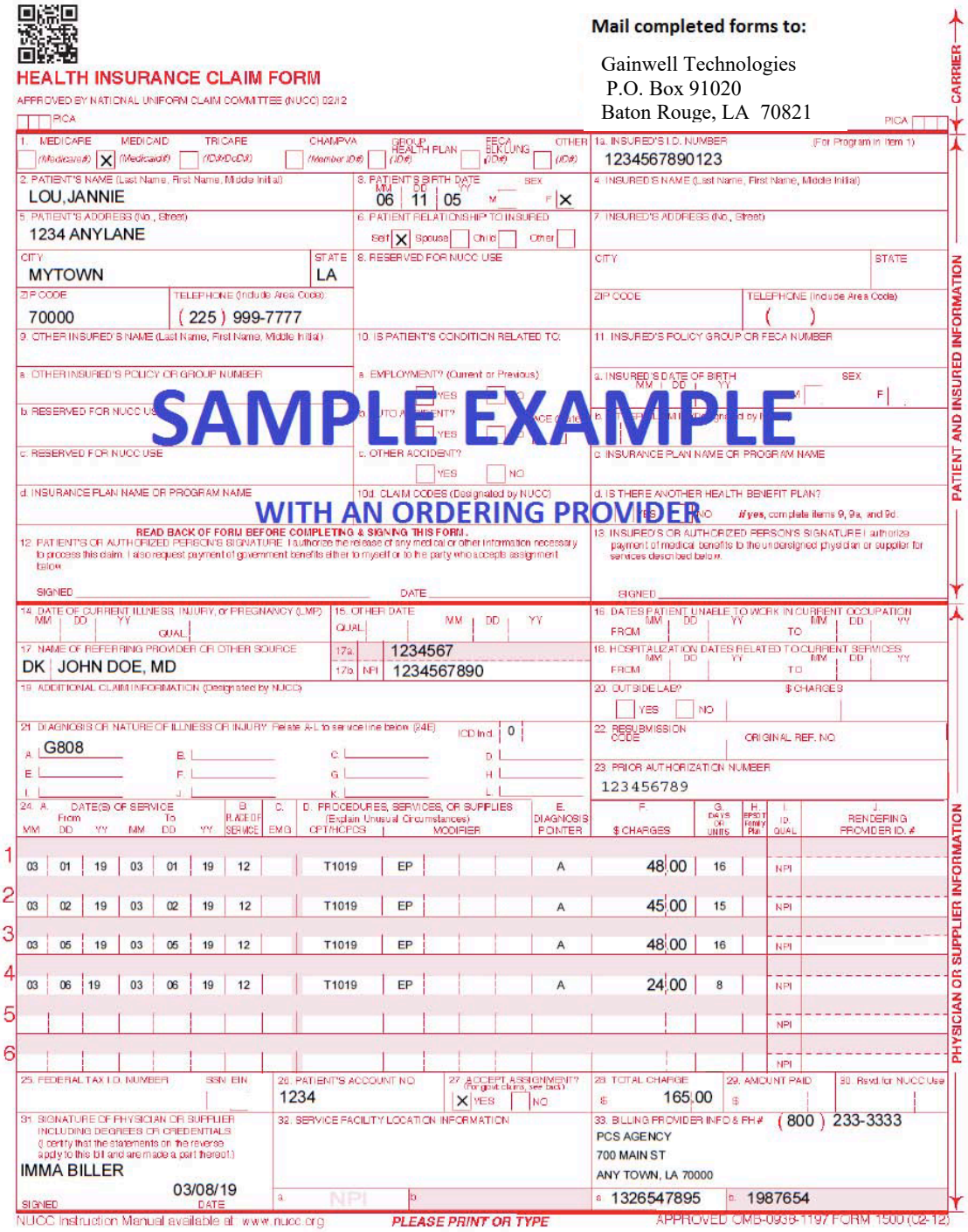
Locator #	Description	Instructions	Alerts
22	Resubmission Code and/or Original Reference Number	**Situational** – If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number (ICN) from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: <u>Adjustments</u> 01 = Third Party Liability (TPL) Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other <u>Voids</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other	**To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.**
23	Prior Authorization (PA) Number	**Required** – Enter the 9-digit PA number for the authorized services.	
24	Supplemental Information	**Situational.**	
24A	Date(s) of Service	**Required** -- Enter the date of service for each procedure. Either 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	**Required** -- Enter the appropriate place of service code for the services rendered.	

Locator #	Description	Instructions	Alerts
24C	EMG	**Leave Blank.**	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). Enter appropriate modifier with procedure code: **UB = LT-PCS** **EP = EPSDT-PCS**	
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D.	
24H	EPSDT Family Plan	**Situational** – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	**Optional.** If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	**Leave Blank.**	
25	Federal Tax I.D. Number	**Optional.**	

Locator #	Description	Instructions	Alerts
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	**Optional.** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Leave Blank.**	
30	Reserved for NUCC use	**Leave Blank.**	
31	Signature of Practitioner or Supplier Including Degrees or Credentials Date	**Optional** – For the PCS CMS 1500, the practitioner or the practitioner's authorized representative's original signature is no longer required. **Required** -- Enter the date of the signature.	
32	Service Facility Location Information	**Situational** – Complete as appropriate or leave blank.	
32a	NPI	**Optional.**	
32b	Unlabeled	**Situational** – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Required –** Enter the billing provider's 10-digit NPI number.	**The 10-digit NPI Number must appear on paper claims.**

Locator #	Description	Instructions	Alerts
33b	Other ID #	**Required** – Enter the billing provider's 7-digit Medicaid ID number. **ID Qualifier** - Optional. If possible, leave blank for Louisiana Medicaid billing.	**The 7-digit Medicaid Provider Number must appear on paper claims.**

Sample PCS Claim Form – See below.



Mail completed forms to:

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

HEALTH INSURANCE CLAIM FORM

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

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LOU,JANNIE

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 05 SEX M F X

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

5. PATIENT'S ADDRESS (No., Street): 1234 ANYLANE

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

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

CITY: MYTOWN STATE: LA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 999-7777

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES

b.

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

SAMPLE EXAMPLE

WITH AN ORDERING PROVIDER

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK JOHN DOE, MD

17a: 1234567

17b NPI: 1234567890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A G808 B C D

E F G H

I J K L

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 123456789

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	03	01	19	03	01	19	12		T1019	EP		A	48.00	16		NPI	
2	03	02	19	03	02	19	12		T1019	EP		A	45.00	15		NPI	
3	03	05	19	03	05	19	12		T1019	EP		A	48.00	16		NPI	
4	03	06	19	03	06	19	12		T1019	EP		A	24.00	8		NPI	
5																NPI	
6																NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234

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

28. TOTAL CHARGE $ 165.00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

IMMA BILLER

SIGNED 03/08/19 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (800) 233-3333

PCS AGENCY
700 MAIN ST
ANY TOWN, LA 70000

a. 1326547895 b. 1987654

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

Adjustments and Voids

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

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

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

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

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

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

Only the paid claim's most recently approved ICN can be adjusted or voided, thus:

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

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

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

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

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

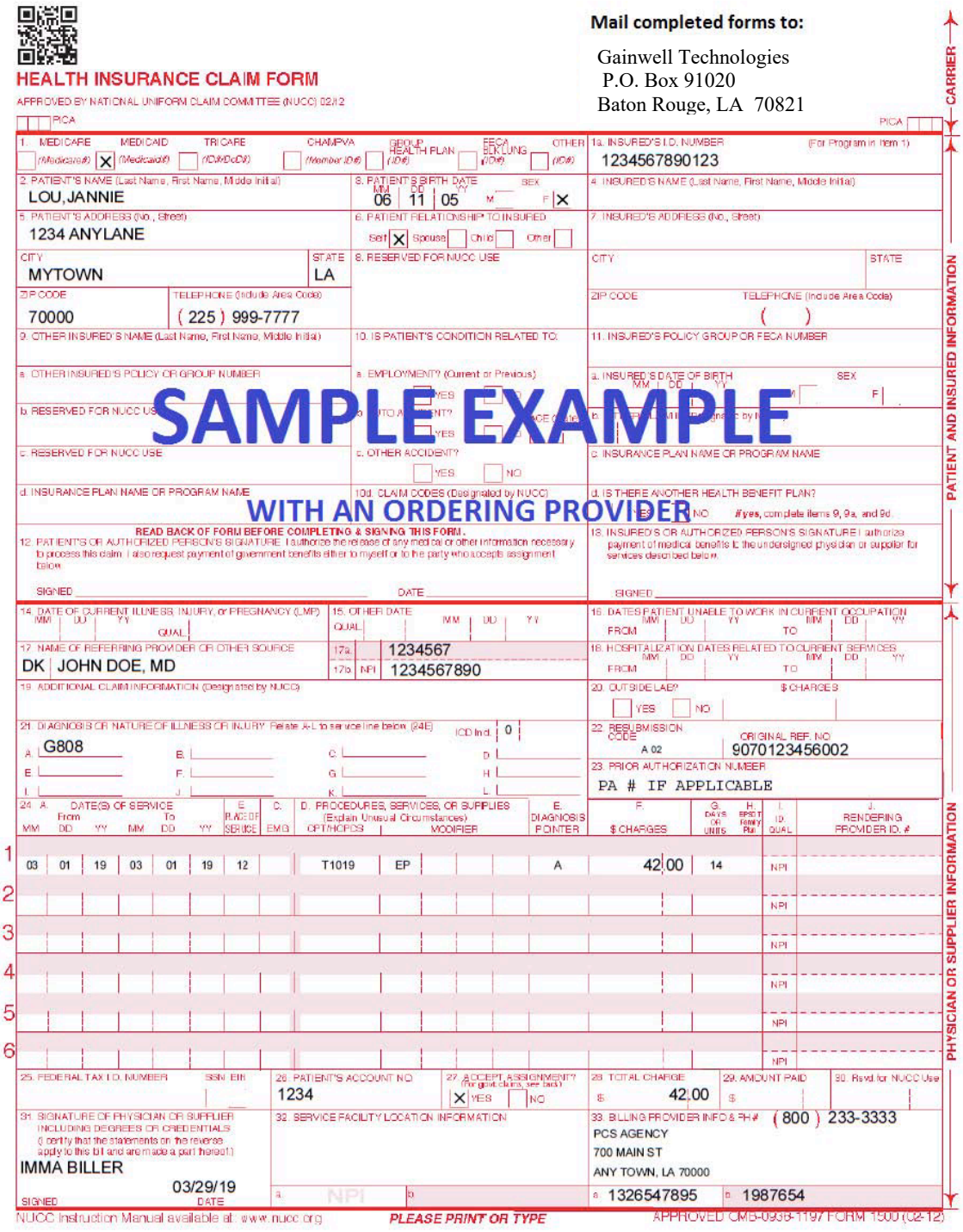
When the void claim is approved, it will be listed under the "Void" column of the RA.

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

Sample PCS Claim Form Adjustment Form – See below.

Mail completed forms to:

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



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CONVICTIONS BARRING EMPLOYMENT

Some criminal convictions prevent employment at a Long-Term – Personal Care Service (LT-PCS) provider agency under 42 CFR 441.404 (b) and La. R.S. 40:1203.1 et seq. **There are NO exceptions to these federal and state laws.**

An individual **CANNOT** be employed at an LT-PCS provider agency if they have been convicted of an offense listed below or if the criminal background check indicates an attempt or conspiracy to commit any of the offenses listed below:

1. R.S. 14: 28.1 (solicitation for murder);
2. R.S. 14: 30-30.1 (first and second degree murder);
3. R.S. 14: 31 (manslaughter);
4. R.S. 14: 32.6-32.7 (first and second degree feticide);
5. R.S.14: 32.12 (criminal assistance to suicide);
6. R.S. 14: 34 (aggravated battery);
7. R.S. 14: 34.1 (second degree battery);
8. R.S. 14:34.7 (aggravated second degree battery);
9. R.S. 14:35.2 (simple battery of the infirmed);
10. R.S. 14:37 (aggravated assault);
11. R.S. 14:37.1 (assault by drive-by shooting);
12. R.S. 14:37.4 (aggravated assault with a firearm);
13. R.S. 14:38.1 (mingling harmful substances);
14. R.S. 14:42 (first-degree rape);
15. R.S. 14:42.1 (second-degree rape);
16. R.S. 14:43 (third-degree rape);

17. R.S. 14:43.1 (sexual battery);

18. R.S. 14:43.2 (second degree sexual battery);

19. R.S. 14:43.3 (oral sexual battery);

20. R.S. 14:43.5 (intentional exposure to AIDS virus);

21. R.S 14:44 (aggravated kidnapping);

22. R.S. 14:44.1 (second degree kidnapping);

23. R.S. 14:44.2 (aggravated kidnapping of a child);

24. R.S. 14:46.2 (human trafficking);

25. R.S. 14:51 (aggravated arson);

26. R.S. 14:60 (aggravated burglary);

27. R.S. 14:62.1 (simple burglary of a pharmacy);

28. R.S. 14:64 (armed robbery);

29. R.S. 14:64.1 (first degree robbery);

30. R.S. 14:64.4 (second degree robbery);

31. R.S. 14:66 (extortion);

32. R.S. 14:67 (theft);

33. R.S. 14:67.21 (theft of the assets of an aged person or disabled person);

34. R.S. 14:80 (felony carnal knowledge of a juvenile);

35. R.S. 14:81.2 (molestation of a juvenile or a person with a physical or mental disability);

36. R.S. 14:89 –14:89.1 (crime and aggravated crimes against nature);

37. R.S. 14:93 (cruelty to juveniles);

38. R.S. 14:93.3 (cruelty to the infirmed);

39. R.S. 14:93.4 (exploitation of the infirmed);

40. R.S. 14:93.5 (sexual battery of the infirmed);

41. Distribution or possession with intent to distribute controlled dangerous substances as listed in Schedules I through V of the Uniform Controlled Dangerous Substances Act; and

42. All other offenses as stated in 42 CFR 441.404 (b) and LA.R.S. 40:1203.1 et seq.