



CHILDREN'S CHOICE WAIVER PROVIDER MANUAL

Chapter Fourteen of the Medicaid Services Manual

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**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

The Children's Choice Waiver is a Medicaid Home and Community-Based Services program that offers supplemental support to children with developmental disabilities who currently live at home with their families, or who will leave an institution to return home. This waiver is unique in that it allows recipients between the ages of birth through 18 years of age to receive a specified monetary amount annually in support services, including support coordination, within a service package individually designed for maximum flexibility. This waiver is an optional service that will be offered to as many children as funding allows. Families of children on the current Developmental Disabilities Request for Services Registry (DDRFSR) will choose to accept a Children's Choice Waiver offer or remain on the DDRFSR. This waiver is operated by the Office for Citizens with Developmental Disabilities (OCDD) under the authorization of the Bureau of Health Services Financing (BHSF). Both OCDD and BHSF are agencies within the Louisiana Department of Health and Hospitals (DHH).

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

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

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

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services, and proper fund disbursement. Should a conflict

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exist between chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

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

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

COVERED SERVICES

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

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

Children's Choice services may be utilized to supplement Early and Periodic Diagnosis, Screening and Treatment (EPSDT) services that are prior approved as medically necessary.

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

Support Coordination

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

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

Family Support Services

Family support services are provided by a personal care attendant that enables a family to keep their child or family member with a developmental disability at home and also enhances family functioning. Services may be provided in the child's home or outside of the child's home in such settings as after school programs, summer camps, or other places as specified in the approved POC. Family support services may not be provided in the following locations:

- A direct service worker's residence, regardless of the relationship, unless the worker's residence is a certified foster care home,
- A hospital once the recipient has been admitted,
- A licensed congregate setting which includes licensed Intermediate Care Facilities for the Developmentally Disabled (ICFs/DD), community homes, center-based respite facilities and day habilitation programs,
- Outside the state of Louisiana, but within the United States or its territories, unless there is a documented emergency or a time-limited exception which has been prior approved by the LGE and included in the recipient's POC, or
- Outside the United States or territories of the United States.

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

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

NOTE: The provider is not allowed to charge the recipient, his/her family member or others a separate fee for transportation as transportation is included in the rate paid to the direct service provider with no specified mileage limit.

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Personal care attendant provider agencies must meet state licensure requirements.

NOTE: Louisiana Children's Choice family support services may be performed the same day as EPSDT Personal Care Services (PCS). When this occurs, recipient records must reflect the services performed in a detailed manner for monitoring purposes. Family support service requires prior authorization from the Office for Citizens with Developmental Disabilities (OCDD). PCS is prior authorized by the Medicaid fiscal intermediary. (See Appendix D for chart on information about differences between these programs)

Children's Choice family support services cannot be provided on the same day at the same time as any other Children's Choice Waiver service except for the following:

- Environmental accessibility adaptations,
- Family training,
- Specialized medical equipment and supplies, or
- Support coordination.

Center-Based Respite Care

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

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

Environmental Accessibility Adaptations

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

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Adaptations to the home may include:

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

Adaptations to the vehicle may include:

- A van lift or
- Other adaptations to make the vehicle accessible to the recipient.

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

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

The following are excluded:

- Adaptations which add to the total square footage of the home,
- Purchase or lease of a vehicle,

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- Regularly scheduled upkeep and maintenance of a vehicle (except upkeep and maintenance of the vehicle modification),
- Adaptations to a vehicle that belongs to someone other than the recipient or the recipient's family,
- Car seats,
- Adaptations or improvements to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the recipient, such as
 - Flooring (carpeting, wood, vinyl, tile, stone, marble, etc.)
 - Roof repair,
 - Interior or exterior walls not directly affected by an adaptation,
 - Central air conditioning, or
 - Fences, etc.
- Fire alarms, smoke detectors, and fire extinguishers.

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

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

It is the support coordinator's responsibility to include Environmental Accessibility Adaptations in the POC or a POC revision request if this service is needed and requested by the recipient/family.

The support coordinator must assist the recipient in completing the "Environmental Accessibility Adaptation Job Completion Form" and any other associated documentation to request prior authorization. (See Appendix D for information on obtaining a copy of this form) The local Human Services Authority or District, hereafter referred to as the local governing entity (LGE), must approve the request prior to any work being initiated.

The environmental accessibility adaptation(s), whether from an original claim, corrected claim, resubmit or revision to the POC, must be accepted by the recipient/family, fully delivered, installed, operational, and completed in the current POC year in which it was approved.

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Payment will not be authorized until written documentation which demonstrates that the job is completed to the satisfaction of the recipient has been received by the support coordinator.

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

Excluded are those durable and non-durable items that are available under the Medicaid State Plan. Support coordinators shall pursue and document all alternate funding sources that are available to the recipient before submitting a request for approval to purchase an Environmental Accessible Adaptation. To avoid delays in service provisions/implementation, the support coordinator should be familiar with the process for obtaining DME through the Medicaid State Plan.

Specialized Medical Equipment and Supplies

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

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

- Sip and puffer switches,
- Other specialized switches, and
- Voice-activated, light-activated, or motion-activated devices to access the recipient's environment.

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

- Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.),
- Swimming pools, hot tubs, etc.,
- Personal computers and software,

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- Daily hygiene products,
- Rent subsidy,
- Food,
- Bed linens (pillows, sheets, etc.),
- Exercise equipment, athletic shoes,
- Adaptive toys, recreation equipment (swing set, etc.),
- Taxi fares, bus passes (intrastate or interstate), etc.,
- Pagers and telephones, including monthly service,
- Home security systems, including monthly service, and
- Durable and non-durable items available under the Medicaid State Plan.

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

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

Family Training

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

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

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

All services provided through programs funded under the Individual with Disabilities Education Act (IDEA: 20 U.S.C. 1401 et seq.) must be utilized before accessing this service.

Professional Services Providers

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

- Applied behavior analysis (ABA)-based therapy,
- Aquatic therapy,
- Art therapy,
- Music therapy,
- Sensory integration, and
- Hippotherapy/therapeutic horseback riding.

Professional services must be delivered with the recipient present and in accordance with the POC.

Applied Behavioral Analysis-Based Therapy

Applied behavioral analysis (ABA)-based therapy is used to assess, teach and modify targeted behaviors in promoting social, emotional and language developmental by reducing behaviors that interfere with learning and cognitive functioning. ABA-based therapies are based on reliable evidence and are not experimental.

Services must be provided by a licensed psychologist or an unlicensed assistant with a master's degree working under the direction of a licensed psychologist. All work performed by the unlicensed assistant must be approved by the licensed psychologist.

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Aquatic Therapy

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

- A chronic illness,
- Poor/lack of muscle tone, or
- A physical injury/disability.

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

Art Therapy

Art therapy is used to:

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

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

Music Therapy

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

Sensory Integration

Sensory integration is used to improve the way the brain processes and adapts to sensory information as opposed to teaching specific skills. Sensory integration involves activities that

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provide vestibular (balance/motion), proprioceptive (visual/sight) and tactile (touch) stimuli which are selected to match specific sensory processing deficits of the recipient.

Hippotherapy/Therapeutic Horseback Riding

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

Hippotherapy

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

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

The licensed therapist must be present during the hippotherapy sessions.

Therapeutic Horseback Riding

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

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

Housing Stabilization Transition and Housing Stabilization Services

Housing stabilization transition and housing stabilization services are provided by Permanent Supportive Housing agencies that are listed as a provider of choice on the FOC form. These services are only available upon referral from the support coordinator for recipients who are

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residing in a state of Louisiana permanent supportive housing unit, or who are linked for the state of Louisiana permanent supportive housing selection process.

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

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

Housing Stabilization Transition Services

Housing stabilization transition services enable recipients who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. This service is provided while the recipient is in an institution and preparing to exit the institution using the waiver. This service includes the following components:

- Conducting a housing assessment to identify the recipient's preferences related to housing (e.g., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing including:
 - Access to housing,
 - Meeting the terms of a lease,
 - Eviction prevention,
 - Budgeting for housing/living expenses,
 - Obtaining/accessing sources of income necessary for rent,
 - Home management,
 - Establishing credit, and
 - Understanding and meeting the obligations of tenancy as defined in the lease terms.
- Assisting the recipient to view and secure housing as needed, which may include arranging for and providing transportation,
- Assisting the recipient to secure supporting documents/records, completing/submitted applications, securing deposits, and locating furnishings,
- Developing an individualized housing support plan based upon the housing assessment that:

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- Includes short and long term measurable goals for each issue,
 - Establishes the recipient's approach to meeting the goal, and
 - Identifies where other provider(s) or services may be required to meet the goal.
-
- Participating in the development of the POC and incorporating elements of the housing support plan, and
 - Exploring alternatives to housing if permanent supportive housing is unavailable to support completion of the transition.

Housing Stabilization Services

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

- Conducting a housing assessment to identify the recipient's preferences related to housing (e.g., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:
 - Access to housing,
 - Meeting the terms of a lease,
 - Eviction prevention,
 - Budgeting for housing/living expenses,
 - Obtaining/accessing sources of income necessary for rent,
 - Home management,
 - Establishing credit, and
 - Understanding and meeting the obligations of tenancy as defined in the lease terms.
- Participating in the development of the POC and incorporating elements of the housing support plan,
- Developing an individualized housing stabilization service provider plan based upon the housing assessment that:
 - Includes short and long term measurable goals for each issue,
 - Establishes the recipient's approach to meeting the goal, and

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- Identifies where other provider(s) or services may be required to meet the goal.
- Providing supports and interventions according to the individualized housing support plan,
- Providing ongoing communication with the landlord or property manager regarding the recipient's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager,
- Updating the housing support plan annually or as needed due to changes in the recipient's situation or status, and
- Providing supports to retain housing or locate and secure housing to continue community-based supports if the recipient's housing is placed at risk (e.g., eviction, loss of roommate or income). This includes locating new housing, sources of income, etc.

Crisis and Non-Crisis Provisions

Families must choose either to accept a slot in Louisiana's Children's Choice Waiver or to remain on the DDRFSR. This is an individual decision based on a family's current circumstances. A family who chooses Children's Choice may later experience a crisis in circumstances that increases the need for paid supports to a level that cannot be accommodated within the cap on waiver expenditures.

Crisis Provision

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

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

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- Child is committed by court to the custody of the Department of Health and Hospitals (DHH),
- Other family crisis with no care giver support available, such as abuse/neglect, or a second person in the household becomes disabled and must be cared for by same care giver, causing inability of the natural care giver to continue necessary supports to assure health and welfare, or
- Physician's documentation of deterioration of the child's condition to the point the POC is inadequate.

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

Process for Determining Qualification for Crisis Designation

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

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

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

The LGE will:

- Review the request immediately upon receipt to determine if all possible natural and community resources have been explored,
- Determine if a new North Carolina – Support Needs Assessment (NC-SNAP) or Health Risk Assessment Tool (HRST) is needed,

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- Make a recommendation regarding support(s) needed and the expected duration of the crisis, and
- Forward the “Request for Crisis Designation” form and supporting documentation to the OCDD State office for final determination.

The OCDD State office will:

- Review the request and the LGE’s recommendations,
- Make a final determination within 48 hours (two business days) of receipt, and
- Notify the LGE of the determination.

Provisions of a Crisis Designation

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

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

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

Eligibility and services through Children’s Choice shall continue as long as the child meets eligibility criteria.

Non-Crisis Provision

Determining Non-Crisis Designation

In addition to satisfying crisis provisions, a recipient may also be allowed to restore his or her name to the DDRFSR in original date order in a “non-crisis provision - other good cause criteria” when all of the following four criteria are met:

- The recipient would benefit from services, that are available through another

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developmental disabilities waiver, which are not available through his/her current waiver or through Medicaid State Plan Services, **AND**

- The recipient would qualify for those services, under the standards utilized for approving and denying services to the developmental disabilities waiver recipients, **AND**
- There has been a change in circumstances, since his or her enrollment in the Children's Choice waiver causing these other services to be more appropriate. A change in the recipient's medical condition is not required. A change in circumstance can include the loss of in-home assistance through a caretaker's decision to take on or increase employment, or to obtain education or training for employment. The temporary absence of a caretaker due to a vacation is not considered "good cause", **AND**
- The person's request date for the developmental disabilities waiver has been passed on the DDRFSR.

Adding the recipient back to the DDRFSR will allow him/her to be placed in the next available waiver slot that will provide the appropriate services provided the recipient is still eligible when the slot is available.

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

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

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

If a Children's Choice recipient's eligibility is terminated based on inability to assure health and welfare of the waiver recipient, DHH will restore the person to the DDRFSR for the developmental disabilities waiver in his/her original date order.

Under regulations and procedures applicable to Medicaid fair hearings, Children's Choice recipients have the right to appeal any determination of DHH as set forth in the non-crisis provisions.

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Process for Non-Crisis/Other Good Cause Designation

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

The LGE will:

- Review the request to determine that all four of the criteria have been met,
- Make a recommendation, and
- Forward the request form, with any supporting documentation to OCDD State office for final determination.

The OCDD State office will:

- Review the request, the LGE's recommendations and any supporting documentation,
- Make a final determination as to whether the individual's name will be returned to DDRFSR, and
- Notify the LGE of the recommendations.

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RECIPIENT REQUIREMENTS

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

- Age between birth and 18 years,
- Name on the Developmental Disabilities Request for Services Registry (DDRFSR),
- Developmental Disability Law criteria as defined in Appendix A,
- Financial and non-financial Medicaid eligibility criteria for home and community-based waiver services:
 - Income less than three times the Supplemental Security Income (SSI) amount for the child (excluding consideration of parental income),
 - Resources less than the SSI resource limit of \$2,000 for a child (excluding consideration of parental resources),
 - SSI disability criteria,
 - Social Security number, and
 - Continuity of stay (has received a waiver service for thirty days or more).
- Intermediate care facility for the developmentally disabled (ICF/DD) level of care criteria which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional,
- Citizenship (U.S. citizen or qualified alien),
- Resident of Louisiana,
- A Plan of Care (POC) that is sufficient to assure the health and welfare of the waiver applicant in order to be approved for waiver participation or continued participation, and
- Justification in the Plan of Care (POC) that the Children's Choice Waiver services are appropriate, cost effective and represent the least restrictive environment for the recipient.

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Children who reach their nineteenth birthday while participating in the Children's Choice Waiver will transfer into an appropriate waiver for adults as long as they remain eligible for waiver services.

Developmental Disabilities Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Requests for waiver services are made through the applicant's local Human Services Authority or District hereafter referred to as the local governing entity (LGE). Only requests from the applicant or his/her authorized representative will be accepted.

Once it has been determined by the LGE that the applicant meets the definition of a developmental disability as defined by the Louisiana Developmental Disability Law (See Appendix A), the applicant's name will be placed on the DDRFSR in request date order and the applicant/family will be sent a letter stating the individual's name has been secured on the DDRFSR along with the original request date. Entry into the Children's Choice Waiver will be offered to applicants from the DDRFSR by date/time order of the earliest request for services for children of appropriate age. If the family chooses to have the child receive services under the Louisiana Children's Choice Waiver, the child's name will be removed from the DDRFSR. Applicants or their family may verify the date of request on the DDRFSR by calling the applicant's LGE.

Medical Certification Eligibility Requirements

Each applicant must meet a separate categorical requirement of disability as defined by the Social Security Administration. If the applicant does not receive SSI, a disability determination is required as part of the eligibility process. The support coordinator will submit medical information to the BHSF. The disability determination is made by the BHSF Medical Eligibility Determination Team and *is separate* from the level of care determination made by the LGE for waiver service eligibility.

Continuity of stay/continuity of care means the individual cannot be certified earlier than 30 days after the first waiver service is provided (at which point coverage can be retroactive to first service, provided all other eligibility criteria is met.)

Exception: Continuity of stay does not apply to SSI recipients.

Application Process

A Louisiana Children's Choice Waiver application does not need to be completed for individuals who are certified for Medicaid long term services in a nursing or ICF/DD facility provided an annual eligibility review was completed and the individual is transferring directly to the

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Louisiana Children's Choice waiver. These individuals already meet Medicaid eligibility requirements. If the individual's level of care in the facility was not ICF/DD, another level of care determination must be made by the LGE.

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

The support coordination agencies will provide intake services, i.e. interview the family, complete the Medicaid application form and assist in gathering medical and other information necessary for eligibility determination. The support coordination agency will then forward the completed application packet to the Bureau of Health Services Financing (BHSF) Medicaid Eligibility Office.

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

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

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

Level of Care

Louisiana Children's Choice Waiver is an alternative to institutional care. All waiver applicants must meet the definition of developmental disability (DD) as defined in Appendix A. The LGE will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD).

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

- Completed 90 days or less before the date the Children's Choice Waiver service is approved to begin and annually thereafter,

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- Completed, signed and dated by the applicant's Louisiana licensed primary care physician, and
- Submitted with the initial or annual POC.

The applicant/family is responsible for obtaining the completed 90-L form from the applicant's primary care physician within the following timeframes:

- Prior to linkage to a support coordination agency for an initial offer.
- No more than 90 days before the annual POC start date.

The support coordinator is responsible for collecting the material necessary to make this determination, and convening the person-centered planning team to formulate the POC, which documents all services to be arranged, including both natural supports and those reimbursed under Louisiana Children's Choice Waiver.

Documentation of level of care and the POC is submitted to the LGE for a decision to determine if the applicant meets the criteria and level of care requirements for admission to an ICF/DD. The LGE assesses the overall support needs of the applicant, including health and welfare, and determines if they will be met by the services and supports designed.

Choice of Service, Support Coordination and Direct Service Providers

Recipients have freedom of choice concerning whether or not to receive Louisiana Children's Choice Waiver services and may select their support coordination agency and direct service providers.

Support Coordination

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

Direct Service Providers

Recipients have freedom of choice of direct service provider agencies that are available in the region where they live. For the first year, a recipient will remain with the same agency.

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SECTION 14.2: RECIPIENT REQUIREMENTS**PAGE(S) 6**

Thereafter, a recipient may change direct service provider agencies every twelve months or at any time for "good cause." (See Section 14.4 "Changing Direct Service Providers" for details on the process of changing service providers)

Admission Denial or Discharge Criteria

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

- Medicaid financial eligibility criteria is not met,
- ICF/DD level of care criteria is not met as determined by the LGE,
- Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities,
- Residence in another state or has a change of residence to another state,
- Admission to an ICF/DD or nursing facility without the intent to return to waiver services. The waiver recipient may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The recipient will be discharged from the waiver on the 91st day if still in the facility. Payment for waiver services will not be authorized when the recipient is in a facility.
- The health, safety and welfare of the individual cannot be assured through the provision of reasonable amounts of waiver services in the community, i.e., presents a danger to himself/herself or others,
- Failure to cooperate in the eligibility determination process, the initial or annual implementation of the POC, or fulfilling his/her responsibilities as a Children's Choice Waiver recipient,
- Continuity of services is interrupted as a result of the recipient not receiving and/or refusing waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

NOTE: Continuity of services will not apply to interruptions due to hospitalization, institutionalization or if a family member has agreed to provide all paid documented supports (not to exceed 90 days) that are listed in the POC during a non-routine lapse of time in waiver services.

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There will not be an authorization for payment of waiver services during this time.

In the event of a Force Majeure, support coordination agencies, direct service providers, and recipients whenever possible, will be informed in writing, and/or by phone and/or via the Louisiana State Medicaid website of interim guidelines and timelines for retention of waiver slots and/or temporary suspension of continuity of services.

The direct service provider is required to notify the support coordination agency within 24 hours if they have knowledge that the recipient has met any of the above stated discharge criteria.

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SECTION 14.3: RIGHTS AND RESPONSIBILITIES**PAGE(S) 3**

RIGHTS AND RESPONSIBILITIES

Recipients of the Children's Choice Waiver services are entitled to the specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Children's Choice Waiver programs.

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

Freedom of Choice of Program

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

Notification of Changes

Support coordinators and service providers may not approve or deny eligibility for the waiver or approve services in the waiver program.

The Department of Health and Hospitals (DHH) - Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for Louisiana Children's Choice. In order to maintain eligibility, recipients have the responsibility to inform BHSF of changes in their income, address, and living situation.

The DHH - Office for Citizens with Developmental Disabilities (OCDD) is responsible for approving level of care and medical certification per the Plan of Care (POC). In order to maintain this certification recipients have the responsibility to inform OCDD through their support coordinator of any significant changes which will affect their service needs.

Participation in Care

Support coordinators and service providers shall allow recipients/families to participate in all person-centered planning meetings and any other meeting concerning their services and supports. Person-centered planning will be utilized in developing all services and supports to meet the

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SECTION 14.3: RIGHTS AND RESPONSIBILITIES**PAGE(S) 3**

recipient's needs. By taking an active part in planning his/her services, the recipient is better able to utilize the available supports and services.

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

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

Freedom of Choice of Support Coordination and Service Providers

The recipient/family has a choice of support coordination agencies and service providers whenever there is a choice available.

Recipients/families may request a change in support coordination agencies by contacting the regional OCDD Waiver Supports and Services Office or Human Service Authority or District.

Support coordinators will provide recipients/families with their choice of direct service providers and help arrange for the service included in the POC.

Voluntary Participation

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

Compliance with Civil Rights

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

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Quality of Care

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

Grievances/Fair Hearings

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

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

Rights and Responsibilities of Families

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

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SECTION 14.4: SERVICE ACCESS AND AUTHORIZATION PAGE(S) 6

SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Children's Choice Waiver opportunity or an existing opportunity is vacated, the next individual on the Developmental Disabilities Request for Services Registry (DDRFSR) will receive a written notice indicating that a waiver opportunity is available. That individual will be evaluated for a possible Children's Choice Waiver opportunity assignment.

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

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

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

- The applicant's assessed needs,
- The types and number of services (including waiver and all other services) necessary to maintain the applicant safely in the community,
- The individual cost of each service (including waiver and all other services), and
- The average cost of services per day covered by the POC.

Provider Selection

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

The support coordinator is responsible for:

- Notifying the provider that the recipient has selected their agency to provide the

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necessary service,

- Requesting the provider sign and return the
 - Provider Agreement form,
 - Emergency plan, and
 - Individualized staffing back-up plan.
- Forwarding the POC packet to the local Human Services Authority or District, hereafter referred to as the local governing entity (LGE), for review and approval.

NOTE: The authorization to provide service is contingent upon approval by the LGE.

Prior Authorization

Prior authorization (PA) is the process to approve specific services prior to service delivery and reimbursement for an enrolled Medicaid recipient by an enrolled Medicaid provider. The purpose of PA is to validate the service that is requested is medically necessary and meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon passing all the edits contained within the claims payment process, the recipient'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 recipient, provider, service code, established quantity of units, and for specific dates of service. Prior authorizations are issued in quarterly intervals directly to the provider, with the last quarterly authorization ending on the POC end date.

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

The service provider is responsible for the following activities:

- Checking prior authorizations to ensure all prior authorizations for services match the approved services in the recipient's POC. Any mistakes must be immediately corrected to match the approved services in the POC.
- Verifying the direct service worker's timesheet is completed correctly and services were delivered according to the recipient's approved POC before billing for the service.

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- Verifying that services were documented as evidenced by timesheets and progress notes and are within the approved service limits as identified in the recipient's POC.
- Completing data entry into the direct service provider data system called Louisiana Services Tracking (LAST).
- Inputting the correct date(s) of service, authorization numbers, provider number, and recipient number in the billing system.
- Billing only for the services that were approved in the recipient's POC and delivered to the recipient.
- Reconciling all remittance advices issued by the DHH fiscal intermediary with each payment.
- Checking billing records to ensure the appropriate payment was received. (**NOTE:** Service providers have one-year timely filing billing requirement under Medicaid regulations.)

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

NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility/institution is involved with special circumstances.

Post Authorization

To receive post authorization, a service provider must enter the required information into the billing system maintained by the Medicaid data contractor. The Medicaid data contractor checks the information entered into the billing system by the service provider against the prior authorized unit(s) of service. Once post authorization is granted, the service provider may bill the DHH fiscal intermediary for the appropriate unit(s) of service.

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

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SECTION 14.4: SERVICE ACCESS AND AUTHORIZATION PAGE(S) 6

Changing Direct Service Providers

Recipients/families may change direct service providers once every twelve months. All requests for changes in services and/or service hours must be made by the recipient/family.

Direct service providers may be changed for good cause at any time as approved by the LGE.

Good cause is defined as:

- A recipient/family moving to another region in the state where the current direct service provider does not or cannot provide services,
- The recipient/family and the direct service provider have unresolved difficulties and mutually agree to a transfer,
- The recipient's health, safety or welfare have been compromised, or
- The direct service provider has not rendered services in a manner satisfactory to the recipient/family.

The recipients/families must contact their support coordinator to change direct service providers. The support coordinator will assist in facilitating a team meeting involving the current direct service provider(s) if agreed to by the recipient/family. This meeting will address the reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider will have the opportunity to submit a corrective action plan with specific time lines, not to exceed 30 days to attempt to meet the needs of the recipient.

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

- Provide the recipient/family with the current Freedom of Choice (FOC) list of service providers in his/her region,
- Assist the recipient/family in completing the FOC and release of information form,
- Ensure the current provider is notified immediately upon knowledge of the request and prior to the transfer,
- Obtain the case record from the releasing provider which must include:

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- Progress notes from the last six months, or if the recipient has received services from the provider for less than six months, all progress notes from date of admission,
- Written documentation of services provided, including monthly and quarterly progress summaries,
- Current POC,
- Records tracking recipient’s progress towards POC goals and objectives,
- Behavior management plans, current and past if applicable,
- Documentation of the amount of authorized services remaining in the POC, including applicable time sheets, and
- Documentation of exit interview.

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

- Most current POC,
- Current assessments on which POC is based,
- Number of services used in the calendar year,
- Records from the previous service provider, and
- All other waiver documents necessary for the new service provider to begin providing supports and services.

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

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

Prior Authorization for New Service Providers

The support coordinator will complete the POC revision from with the start date for the new provider and the end date for the transferring provider and submit the revision request to the LGE for approval. Upon approval, a new PA number will be issued to the new provider with the effective starting date. The transferring agency’s PA number will expire on the date immediately preceding the PA date for the new provider.

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Neither the LGE nor its agent will backdate the new PA period to the first day of the first full calendar month in which the FOC and transfer of records are completed. If the new provider receives the records and admits a recipient in the middle of a month, the new provider cannot bill for services until the first day of the next month. New providers who provide services prior to the begin date of the new PA period will not be reimbursed.

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

Changing Support Coordination Agencies

A recipient may change support coordination agencies after a 12-month period or at any time for good cause if the new agency has not met their maximum number of recipients. Thereafter, a recipient may request a change in support coordination agencies every 12 months. Good cause is defined as:

- A recipient/family moving to another region in the state,
- The recipient/family and the support coordination agency have unresolved difficulties and mutually agree to a transfer,
- The recipient's health, safety or welfare have been compromised, or
- The support coordination agency has not rendered services in a manner satisfactory to the recipient/family.

Participating support coordination agencies should refer to Section 14.11 – Support Coordination which provides a detailed description of their roles and responsibilities.

Changes in Authorized Services

Any change or revision to the POC must be prior approved by the LGE. Requests for changes to the POC must be made by the recipient/family to the support coordinator. Changes will not be made solely on the request of the service provider.

The recipient/family may not authorize services or authorize direct service workers to work hours or services not included in the approved POC.

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SECTION 14.5: PROVIDER REQUIREMENTS**PAGE(S) 9**

PROVIDER REQUIREMENTS

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

- Meet all of the requirements for licensure as established by state laws and rules promulgated by the Department of Health and Hospitals (DHH),
- Agree to abide by all rules and regulations established by the Centers for Medicare and Medicaid Services (CMS), DHH and other state agencies if applicable, and
- Comply with all the terms and conditions for Medicaid enrollment.

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

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

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

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

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

Providers must develop a Quality Improvement and Self-Assessment Plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first Self-Assessment is due six months after approval of the Quality Improvement Plan and yearly thereafter. The

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Quality Improvement Plan must be submitted for approval within 60 days after the training is provided by DHH.

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

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

Changes in the following areas are to be reported to the DHH Health Standards Section, OCDD and the fiscal intermediary's Provider Enrollment Section in writing at least 10 days prior to any change:

- Ownership,
- Physical location,
- Mailing address,
- Telephone number, and
- Account information affecting electronic funds transfer (EFT).

The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving recipients. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving recipients until the re-certification process is complete.

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

Providers may not refuse to serve any waiver recipient that chooses their agency unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. Such refusal to serve an individual must be put in writing by the provider, and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the local Human Service Authority or District, hereafter referred to as the local governing entity (LGE). Providers who contract with other entities to

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provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver recipient referred to them by the enrolled direct service provider agency.

The recipient's provider and support coordination agency must have a written working agreement that includes the following:

- Written notification of the time frames for POC planning meetings,
- Timely notification of meeting dates and times to allow for provider participation,
- Information on how the agency is notified when there is a POC or service delivery change, and
- Assurance that the appropriate provider representative is present at planning meetings as invited by the recipient.

Support Coordination Provider Requirements

Providers of support coordination for the Children's Choice Waiver program must

- Have a current, valid support coordination license,
- Meet all requirements for targeted case management services as set forth in Louisiana Administrative Code 50:XV Chapter 105,
- Have a signed performance agreement with OCDD to provide services to waiver recipients. Support coordination agencies must meet all of the performance agreement requirements, and
- Meet any additional criteria outlined in the Medicaid Case Management Services manual chapter.

Direct Service Provider Requirements

Direct service providers must be licensed by the DHH as a Home and Community-Based Services Provider and meet the module specific requirements for the services being provided. Direct service providers must provide at a minimum the Family Support and Crisis Support services. Other direct services outlined below may be provided directly by the direct service provider or by a written agreement (subcontract) with other agents. The actual provider of the

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service, whether it is the direct service provider or a subcontracted agent, must meet the following licensure or other qualifications:

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

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

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

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

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

Professional Services Provider Requirements

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

- Have a current, valid license or certification from the appropriate governing board for that profession, and
- Possess one year of post-licensure or certification experience consistent with the scope of the license or certification held by the professional.

Provider Responsibilities

Support Coordination Providers

Support coordination providers are responsible for the following:

- Facilitating the development of the POC with the recipient/family, authorized representative and direct service provider,
- Reviewing the POC at least quarterly to:

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- Determine that the goals and objectives in the POC have been achieved,
 - Determine that the recipient’s needs are being met,
 - Assess satisfaction with scheduled services, and
 - Make adjustments or changes to the POC, if necessary.
-
- Revising the POC when requests are made from the recipient/family, and
 - Scheduling and facilitating the annual POC meeting.

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

Direct Service Providers

The direct service provider is responsible for the following:

- Ensuring an appropriate representative from the agency attends the POC planning meeting and is an active participant in the team meeting,

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

- Communicating and working with support coordinators and other support team members to achieve the recipient’s personal outcomes,
- Ensuring the recipient’s emergency contact information and list of medications are kept current,
- Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or time lines in the POC will not meet the recipient’s needs, but not later than 10 days prior to the expiration of any time lines in the POC that cannot be met,
- Ensuring all support team members sign and date any revisions to the POC indicating agreement with the changes to the goals, objectives or time lines,

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- Providing the support coordination agency or DHH representatives with requested written documentation including, but not limited to:
 - Completed, signed and dated POC,
 - Service logs, progress notes, and progress summaries,
 - Direct service worker attendance and payroll records,
 - Written grievances or complaints filed by recipients/family,
 - Critical or other incident reports involving the recipient, and
 - Entrance and exit interview documentation,
- Ensuring all staff receives training within established time lines as specified in licenses, certifications, etc.,
- Explaining to the recipient/family in his/her native language the recipient rights and responsibilities within the agency, and
- Assuring that recipients are free to make a choice of providers without undue influence.

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

- Training policy that includes orientation and staff training requirements according to the HCBS Provider Minimum Licensing Standards for Personal Care Attendant and the Direct Service Worker Registry rule,
- Direct care abilities, skills and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver recipients,
- Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing and staff coverage plan,
- Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal,
- Identification, notification and protection of recipient's rights both verbally and in writing in a language the recipient/family is able to understand,
- Written grievance procedures, and

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- Information about abuse and neglect as defined by DHH regulations and state and federal laws.

Back-up Planning

Direct service providers are responsible for providing all necessary staff to fulfill the health and welfare needs of the recipient when paid supports are scheduled to be provided. This includes times when the scheduled direct service worker is absent or unavailable or unable to work for any reason.

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

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

Emergency Evacuation Planning

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

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

- Individualized risk assessment of potential health emergencies,
- A detailed plan that addresses the recipient's evacuation needs, including a review of the recipient's back-up plan during geographical and natural disaster emergencies and all other potential emergency conditions,

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- Policies and procedures outlining the agency's implementation of emergency evacuation plans and the coordination of these plans with the local Office for Emergency Preparedness and Homeland Security,
- Establishment of effective lines of communication and chain-of-command procedures,
- Establishment of procedures for the dissemination of the emergency evacuation plan to recipients and support coordinators, and
- Protocols outlining how and when direct service workers and recipients will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

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

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

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STAFFING REQUIREMENTS

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

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

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in 42 CFR 441.404 (b) which states providers of community supported living arrangements services do not employ individuals who have been convicted of child abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual and take all reasonable steps to determine whether applications for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

Failure to comply with these regulations may result in any or all of the following: recoupment, sanctions, loss of enrollment, or loss of licensure.

Support Coordination Requirements

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

Direct Service Provider Requirements

Direct service providers must ensure that all direct service staff possess the minimum requisite skills, qualifications, training, supervision, and coverage in accordance with the Personal Care Attendant Licensing Standards, the Home and Community Based Services Waiver Program Standards of Participation, and the Direct Service Worker Registry. Providers must maintain sufficient staff and office site(s) to adequately serve recipients in the DHH region(s) where they are enrolled. A supervisor must also be continuously available to direct care staff by telephone or beeper at all times when not on site.

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

- Legally responsible relatives (spouses, parents or stepparents, foster parents, or legal guardians); or
- Any other relative who lives in the same household with the recipient.

Family members who provide family support services must meet the same standards for employment as caregivers who are unrelated to the recipient.

RECORD KEEPING

Components of Record Keeping

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

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

Confidentiality and Protection of Records

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

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the recipients or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the recipients or their families. The wrongful disclosure of such information may result in the imposition by the DHH or whatever sanctions are available pursuant to Medicaid certification authority or the imposition of a monetary fine and/or imprisonment by the United States Government pursuant to the HIPAA Privacy Rule. The information may be released only under the following conditions:

- Court order,
- Recipient's written informed consent for release of information,
- Written consent of the individual to whom the recipient's rights have been devolved when the recipient has been declared legally incompetent, or
- Written consent of the parent or legal guardian when the recipient is a minor.

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

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

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

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

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

Review by State and Federal Agencies

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

Retention of Records

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

- Until records are audited and all audit questions have been answered to the satisfaction of all parties involved,

OR

- Five years from the date of the last payment period.

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

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Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, the DHH Home and Community Based Waiver Services Standards for Participation rule and Medicaid enrollment agreements.

Recipient Records

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

Recipient records and location of documents within the record must be consistent among all records. Records must be appropriately maintained so that current material can be located in the record.

The OCDD does not prescribe a specific format for documentation, but must find all components outlined below in each recipient's active record.

Organization of Records, Record Entries and Corrections

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

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

- Name of the person making the entry,
- Signature of the person making the entry,
- Functional title of the person making the entry,
- Full date of documentation, and
- Supervisor review, if required.

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Any error made by the staff in a recipient'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 recipient's records.

Components of Recipient Records

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

- Identifying information on the recipient that is recorded on a standardized form to include the following:
 - Name,
 - Home address,
 - Home telephone number,
 - Date of birth,
 - Sex,
 - List of current medications,
 - Primary and secondary disability,
 - Name and phone number of preferred hospital,
 - Closest living relative,
 - Marital status,
 - Name and address of current employment, school, or day program, as appropriate,
 - Date of initial contact,
 - Court and/or legal status, including relevant legal documents, if applicable,
 - Names, addresses, and phone numbers of other recipients or providers involved with the recipient's Plan of Care (POC) including the recipient's primary or attending physician,
 - Date this information was gathered, and
 - Signature of the staff member gathering the information.
- Documentation of the need for ongoing services,
- Medicaid eligibility information,
- A copy of assurances of freedom of choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc. signed by the recipient,

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- Approved POC, including any revisions,
 - Complete Individualized Service Plan (ISP),
 - Copy of all critical incident reports, if applicable,
 - Formal grievances filed by the recipient,
 - Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified in the Service Documentation section,
 - Attendance records,
 - Copy of the recipient's behavior support plan, if applicable,
 - Documentation of all interventions (medical, consultative, environmental and adaptive) used to ensure the recipient's health, safety, and welfare,
 - Reason for case closure and any agreements with the recipient at closure,
 - Copies of all pertinent correspondence,
 - At least six months (or all information if services provided less than 6 months) of current pertinent information relating to services provided,
- NOTE:** Records older than six months may be kept in storage files or folders, but must be available for review.
- Any threatening medical condition including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or any known allergies,
 - Monitoring reports of waiver service providers to ensure that the services outlined in the POC are delivered as specified,
 - Service logs describing all contacts, services delivered and/or action taken identifying the recipients involved in service delivery, the date and place of service, the content of service delivery and the services relative to the POC,
 - A sign-out sheet that indicates the date and signature of the person(s) who viewed

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the record, and

- Any other pertinent documents.

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

- Name,
- Telephone number,
- Address,
- Emergency contacts,
- Medicaid and/or Medicare insurance number and any other insurance card number,
- Current medications,
- Physician's name, telephone number and address,
- Preferred hospital,
- Current medical conditions including allergies, and
- Preferred religion (if stated).

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

Service Documentation

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

Required service documentation includes:

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- Service logs,
- Progress notes,
- Progress summaries,
- Discharge summaries for transfers and closures, and
- Individualized documentation.

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

Service Logs

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

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

- Name of recipient,
- Name of provider and employee providing the service,
- Service agency contact telephone number,
- Date of service contact,
- Start and stop time of service contact,
- Purpose of service contact,
 - Personal outcomes addressed
 - Other issues addressed
- Content and outcome of service contact, and
- Place of service contact.

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There must be case record entries corresponding to each recorded support coordination and direct service provider activity which relates to one of the personal outcomes.

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

Services billed must clearly be related to the current POC.

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

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

Progress Notes

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

- Reflect descriptions of activities, procedures, and incidents,
- Give a picture of the service provided to the recipient,
- Show progress towards the recipient's personal outcomes,
- Record any change in the recipient's medical condition, behavior, or home situation which may indicate a need for reassessment and POC change,
- Record any changes or deviations from the typical weekly schedule in the recipient's approved POC, and
- Reflect each entry in the service log and/or timesheet.

Checklists alone are not adequate documentation for progress notes.

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

- “Supported _____”
- “Assisted _____”
- “_____ is doing fine”
- “_____ had a good day”
- “Prepared meals”

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

Progress Summary

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

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

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

Discharge Summary for Transfers and Closures

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

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

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Individualized Documentation

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

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

- Seizure disorder and/or receiving seizure medication – Data forms used to track this information must include seizure reports. The support team may also need to consider assessing for the presence of side-effects of seizure medication on a monthly or quarterly basis.
- A medical issue which is significantly affected by or has a significant effect upon one's weight – Such issues may include diabetes, cardiovascular issues, medication side-effects, or receiving nutrition via g-tube, peg-tube, etc. Data forms used to track this information must include weight logs. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, and assessing for the presence of medication side-effects.
- Medications which can have severe side effects or potentially cause death if the adherence to medication management protocols is not strictly followed - Data forms used to track this information must include an assessment for the presence of medication side-effects on a monthly or quarterly basis. The support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, and tracking frequency/consistency of bowel movements with a daily bowel log.
- A psychiatric diagnosis and/or receiving psychotropic medication – Data forms used to track this information must include a psychiatric symptoms assessment. Based on the recipient's presenting symptoms, antecedents, and psychotropic medication guidelines, the support team may also need to consider tracking meal/fluid intake with a daily meal/fluid log, tracking frequency/consistency of bowel movements with a daily bowel log, tracking frequency of menstrual cycles with a menstrual chart, tracking sleep patterns with a sleep log, tracking frequency/intensity of challenging behaviors with a challenging behavior chart, and assessing for the presence of medication side-effects.

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

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

Schedule of Required Documentation

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

REIMBURSEMENT

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

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

All claims for Children’s Choice Waiver services shall be filed by electronic claims submissions 837P or on the CMS 1500 claim form.

PROGRAM MONITORING

Services offered through Louisiana Children's Choice are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal regulations. The Medicaid's Health Standards Section (HSS) staff or its designee conducts on-site reviews of each provider agency. These reviews are conducted to monitor the provider agency's compliance with Medicaid's provider enrollment participation requirements, continued capacity for service delivery, quality and appropriateness of service provision to the waiver group, and the presence of the personal outcomes defined and prioritized by the individuals served.

The HSS reviews include a review of administrative records, personnel records, and a sample of recipient records. In addition, provider agencies are monitored with respect to:

- Recipient's access to needed services identified in the service plan,
- Quality of assessment and service planning,
- Appropriateness of services provided including content, intensity, frequency and recipient input and satisfaction,
- The presence of the personal outcomes as defined and prioritized by the recipient/guardian, and
- Internal quality improvement.

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

On-Site Reviews

On-site reviews with the provider agency are unannounced and conducted by HSS staff to:

- Ensure compliance with program requirements, and
- Ensure that services provided are appropriate to meet the needs of the recipients served.

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Administrative Review

The Administrative Review includes:

- A review of administrative records,
- A review of other provider agency documentation, and
- Provider agency staff interviews as well as interviews with a sampling of recipients to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the HSS monitoring questions or findings may result in sanctions, liquidated damages and/or recoupment of payment.

Interviews

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

- A representative sample of the individuals served by each provider agency employee,
- Members of the recipient's circle or network of support, which may include family and friends,
- Service providers, and
- Other members of the recipient's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, and direct service providers and other employees of the direct service provider agency.

This interview process is to assess the overall satisfaction of recipients/families regarding the provider agency's performance, and to determine the presence of the personal outcomes defined and prioritized by the recipient/guardian.

Personnel Record Review

The Personnel Record Review includes:

- A review of personnel files,

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- A review of time sheets, and
- A review of the current organizational chart.

Recipient Record Review

A representative sample of recipient records are reviewed to ensure the services and supports delivered to recipients are rendered according to the recipient's approved Plan of Care. The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the recipients served.

Recipient records are reviewed to ensure that the activities of the provider agency are correlated with the appropriate services of intake, ongoing assessment, planning (development of the Plan of Care), transition/closure, and that these activities are effective in assisting the recipient to attain or maintain the desired personal outcomes.

Documentation is reviewed to ensure that the services reimbursed were

- Identified in the Plan of Care,
- Provided,
- Documented properly,
- Appropriate in terms of frequency and intensity, and
- Refer to the personal outcomes on the Plan of Care.

Provider Staff Interviews

Provider agency staff is interviewed as part of the on-site review to ensure that the following staff and agency qualifications are being met:

- Education,
- Experience,
- Skills,
- Knowledge,

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- Employment status,
- Hours worked,
- Staff coverage,
- Supervisor to staff ratio,
- Caseload/recipient assignments,
- Supervision documentation, and
- Other applicable requirements.

Monitoring Report

Upon completion of the on-site review, the HSS staff discusses the preliminary findings of the review in an exit interview with appropriate provider staff. The HSS staff compiles and analyzes all data collected in the review, and a written report summarizing the monitoring findings and recommended corrective action is sent to the provider agency.

The monitoring report includes:

- Identifying information, and
- A statement of compliance with all applicable regulations or a report of deficiencies requiring corrective action by the provider.

The HSS program managers will review the reports 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 report**.

The plan must address *how each cited deficiency has been corrected and how recurrences will be prevented*. The provider is afforded an opportunity to discuss or challenge the HSS monitoring 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

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have not been addressed, the HSS program manager responds to the provider requesting immediate resolution of those deficiencies in question.

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

Informal Dispute Resolution (Optional)

In the course of monitoring duties, an informal hearing process may be requested. The provider is notified in writing of the right to an informal hearing that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits the right of the provider to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix C for contact information)

This request must be made within the time limit given for the corrective action recommended by the HSS.

The provider is notified of the time and place of the informal hearing. The provider should bring all supporting documentation that is to be submitted for consideration. Every effort will be made to schedule a hearing at the convenience of the provider.

The HSS program manager convenes the informal hearing and providers are given the opportunity to present their case and to explain their disagreement with the monitoring findings. The provider representatives are advised of the date to expect a written response and are reminded of their right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Department of Health and Hospitals' (DHH) Bureau of Appeals.

Fraud and Abuse

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

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Quality Management

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

- Learning,
- Responding,
- Implementing, and
- Evaluating.

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

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INCIDENTS, ACCIDENTS AND COMPLAINTS

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

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

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

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

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

Internal Complaint Policy

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

- Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint.
- If the complaint is verbal, the provider staff member receiving the complaint must obtain and send all pertinent information in writing to the provider complaint

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coordinator. If the recipient/guardian completes the complaint form, the provider staff will be responsible for sending the form to the provider complaint coordinator.

- The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within five working days**.
- The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the recipient/guardian, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution.
- The provider's administrator or designee must inform the recipient and/or the personal representative in writing **within ten working days** of receipt of the complaint, the results of the internal investigation.
- If the recipient/guardian is dissatisfied with the results of the internal investigation regarding the complaint, he/she may continue the complaint resolution process by contacting the regional OCDD Waiver Services and Supports Office or Human Services Authority or District in writing, or by telephone.

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

Complainant Disclosure Statement

La. R.S. 40:2009.13 - .21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the Home and Community-Based Services waiver programs. When the substance of the complaint is furnished to the service provider, it shall not identify the complainant or the recipient unless he/she consents in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

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

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If the complainant still elects to file the complaint, the OCDD will mail or FAX the disclosure form to the complainant with instructions to return it to the OCDD Central Office.

Definition of Related Terms Regarding Incidents and Complaints

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

- Complaint - an allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a recipient (La. R.S. 40:2009.14)
- Minimal harm - is an incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the recipient's activities of daily living. (La. R.S. 40:2009.14)
- Trivial report - is an account of an allegation that an incident has occurred to a recipient or recipients that causes no physical or emotional harm and has no potential for causing harm to the recipient or recipients. (La. R.S. 40:2009.14)
- Allegation of noncompliance - is an accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a recipient or recipients. (La. R.S. 40:2009.14)
- Abuse – Any of the following acts which seriously endanger the physical, mental, or emotional health and safety of a child including:
 - The infliction or attempted infliction, or as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon a child by a parent or by any other person.
 - The exploitation or overwork of a child by a parent or by any other person.
 - The involvement of a child in any sexual act with a parent or with any other person, or the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, or the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code Article 1003).
- Disabled person - is a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for his/her

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own care or protection.

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

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SUPPORT COORDINATION

Support coordination, which is also referred to as case management, is a waiver service that is provided to all Children's Choice Waiver recipients. Support coordination is an organized system by which a support coordinator assists a recipient to prioritize and define his/her personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Recipients may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies are required to perform the following:

- Intake,
- Assessment,
- Plan of Care Development and Implementation,
- Follow-Up/Monitoring,
- Reassessment, and
- Transition/Closure.

Intake

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

Intake Procedures

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

The Plan of Care (POC) process begins with an initial face-to-face meeting in the recipient's home. The support coordinator requests and gathers medical, social, educational and

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psychological documentation necessary to complete the POC. The local Human Services Authority or District, hereafter referred to as the local governing entity (LGE), will transfer eligibility documents with the transfer of records to the support coordination agency. Prior authorization to cover services from the beginning date of the POC will be issued upon approval of the POC.

The support coordinator must determine whether the applicant:

- Has a need for immediate support coordination intervention, and
- Is receiving support coordination service or other services from another provider or community resource.

NOTE: If the applicant is receiving support coordination from another OCDD provider, the OCDD State Office Support Coordination Program Manager must be contacted to correct the linkage. (See Appendix C for contact information)

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

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

- Was informed of procedural safeguards,
- Was informed of their rights along with grievance procedures,
- Was advised of their responsibilities,
- Accepted support coordination service,
- Was advised of the right to change support coordination providers, support coordinators, service providers, and
- Was advised that waiver services and support coordination service are an alternative to institutionalization.

If the services in the Children's Choice Waiver are not appropriate to meet the applicant's needs, or if the applicant does not meet the eligibility requirements for waiver services, the applicant

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should be notified immediately, given appeal rights and directed to other service options or to the source of the initial referral.

Assessment

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

Assessment Process

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

- Face-to-face home interviews with the recipient/recipient's family or guardian,
- Direct observation of the recipient,
- Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the recipient, and
- Freedom of choice of all services, support coordination and alternative to institutionalization.

Characteristics and components of the assessment include:

- Identifying information (demographics),
- The use of a standardized instrument for certain targeted populations,
- Personal outcomes identified, defined and prioritized by the recipient,
- Medical/physical information,
- Psycho social/behavioral information,
- Developmental/intellectual information,

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- Socialization/recreational information including the social environment and relationships that are important to the recipient,
- Patterns of the recipient's everyday life,
- Financial resources,
- Educational/vocational information,
- Housing/physical environment of the recipient,
- Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes,
- Information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes, (e.g., input from formal and informal service providers and caregivers as relevant to the personal outcomes), and
- Identification of areas where a professional evaluation is necessary to determine appropriate services or interventions.

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

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

Time Frame for Initial Assessment

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

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Ongoing Assessment Procedures

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

Plan of Care Development and Implementation

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

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

The POC serves to:

- Establish direction for all persons involved in providing supports and services for the recipient by describing how the needed supports and services interact to form overall strategies that assist the recipient to maintain or achieve the desired personal outcomes.
- Provide a process for ensuring that the paid medical services and other resources are deemed medically necessary and meet the needs of the recipient including health and welfare as determined by the assessment, and that these services and supports are provided in a cost-effective manner.
- Represent a strategy for ensuring that services are appropriate, available, and responsive to the recipient's changing outcomes and needs as updated in the assessment.

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

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Required Procedures

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

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

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

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

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

Required Components

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

- The recipient's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed, paid formal services,
- Budget payment mechanism, as applicable,

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- Target/resolution dates for the achievement/maintenance of personal outcome,
- Assigned responsibilities,
- Identified preferred formal and informal support/service providers and the specific service arrangements,
- Identified individuals who will assist the support coordinator in planning, building/implementing supports, or direct services,
- Ensured flexibility of frequency, intensity, location, time and method of each service or intervention and is consistent with the POC and recipient's desired outcomes,
- Change in a waiver service provider(s) can only be requested by the recipient at the end of a 12-month linkage unless there is "good cause." Any request for a change requires a completion of a Freedom of Choice form. A change in support coordination providers is to be made through the Medicaid data contractor. A change in direct service providers is to be made through the support coordinator,
- All participants present at the POC meeting must sign the POC,
- The POC must be completed and approved as per POC instructions,
- The recipient must be informed of his/her right to refuse a POC after carefully reviewing it.

Building and Implementing Supports

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

Responsibilities of the support coordinator include:

- Building and implementing the supports and services as described in the POC,
- Assisting the recipient/family to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the POC,

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- Being aware of and providing information to the recipient/family on potential community resources, including formal resources (Food Stamps, Supplemental Security Income, housing, Medicaid, etc.) and informal/natural resources, which may be useful in developing strategies to support the recipient in attaining his or her desired personal outcomes,
- Assisting with problem solving with the recipient, supports, and services providers,
- Assisting the recipient to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet their individual needs,
- Advocating on behalf of the recipient to assist in obtaining benefits, supports or services, e.g., to help establish, expand, maintain and strengthen the recipient's informal and natural support networks by calling and/or visiting recipients, community groups, organizations, or agencies with or on behalf of the recipient,
- Training and supporting the recipient in self-advocacy, e.g., selection of providers and utilization of community resources to achieve and maintain the desired outcomes,
- Overseeing the service providers to ensure the recipient receives appropriate services and outcomes as designed in the POC,
- Assisting the recipient to overcome obstacles, recognize potential opportunities and develop creative opportunities, and
- Meeting with the recipient face-to-face in the recipient's home between a six and nine month period and for each annual POC development, or more often if requested by the recipient/family.

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

Required Time Frames

- Linkage

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

- **Changes**

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

- **Emergencies**

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

- **Reviews**

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

The POC must be revised annually (and as required) and submitted to the LGE no later than 35 days prior to expiration. The POC may be submitted as early as 90 days prior to expiration provided the form 90-L does not expire prior to the POC expiration date.

Changes in the Plan of Care

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

There is flexibility in the POC for the family to use the services as needed as long as the reimbursement from Medicaid remains within the waiver cap. Therefore, changes will occur only when a service is added or removed from the POC.

Initiating a Change in the Plan of Care

The recipient/family will contact the support coordinator when a change is required. The support coordinator will call a meeting with the service provider to complete the POC revision form. All

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participants will sign the POC revision and it will be submitted to the LGE for approval. The support coordinator will notify the service provider and recipient of the approval/disapproval.

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

Documentation

The POC must include the frequency and location of the support coordinators' face-to-face contacts with the recipient.

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

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

Follow-Up/Monitoring

Follow-up/monitoring is the mechanism used by the support coordinator to assure the appropriateness of the POC. Through follow-up/monitoring activity, the support coordinator not only determines the effectiveness of the POC in meeting the recipient's needs, but identifies when changes in the recipient's status necessitate a revision in the POC. The purpose of the follow-up/monitoring contacts is to determine:

- If services are being delivered as planned,
- If services are effective and adequate to meet the recipient's needs, and
- Whether the recipient is satisfied with the services.

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

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

- Does the recipient/family feel the outcomes are being met,
- Are the times the services are being provided convenient and satisfactory to the recipient/family,

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- Does the recipient/family have any problems or changes that may require additional services,
- Are the providers actually present at the times indicated, and
- Are the provided services adequate and of good quality.

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

Notify service providers within three working days of written changes in the POC.

Meet with the recipient between the sixth and ninth month of implementation of the POC to determine the effectiveness of the support strategies and, if necessary, to revise the POC.

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

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

- Desired personal outcomes,
- Strategies to achieve the outcomes,
- Effectiveness of the strategies,
- Obstacles to achieving the desired outcomes,
- New opportunities, and
- Developing a new action plan.

Reassessment

Assessment must be ongoing to reflect changes in the recipient's life and the changing prioritized personal outcomes over time such as strengths, needs, preferences, abilities and the recipient's

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resources. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall POC.

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

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

Six-month Reassessment

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

Annual Reassessment

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

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

- The recipient's health and welfare can be assured,
- There are no changes in waiver services, and
- The current waiver services are meeting the needs of the recipient.

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

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

- Skilled nursing care,

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- Direct service worker given delegation for medication administration or delegation for a complex or non-complex task,
- Crisis or non-crisis designation was requested,
- There were three or more critical incident reports during the POC year, or
- There was any report with a substantiated investigation to the Department of Children and Family Services' Child Welfare Division or the Department of Health and Hospital's Adult Protective Services.

Transition/Closure

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

Closure Criteria

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

- The recipient requests termination of services,
- Death,
- Permanent relocation of the recipient out of the service area (transfer to another region) or out of state,
- Long term admission to a hospital, institution or nursing facility,
- The recipient requires a level of care beyond that which can safely be provided through waiver services,
- 30-day hospitalization/institutional rule (Continuity of Stay Rule), or
- Recipient refuses to comply with support coordination.

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Procedures for Transition/Closure

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

- Notify the recipient/family immediately if the recipient becomes ineligible for services,
- Complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient methods of negotiating their own service needs,
- Notify the service provider immediately if services are being transitioned or closed,
- Assure the receiving agency, program or support coordinator receives copies of the most current POC and related documents. (The form 148-W must be completed to reflect the date on the transfer of records and submitted to the LGE.)

The support coordination agency must:

- Notify the LGE of the transition/closure four weeks prior to the closure to allow the LGE to establish a transition plan,
- Follow their own policies and procedures regarding intake and closure, and
- Serve as a resource to recipients who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities. All closures must be entered into the database immediately.

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

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

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SECTION 14.11: SUPPORT COORDINATION**PAGE(S) 16**

Transition at Age 19

As long as a recipient remains eligible for waiver services, when the recipient reaches age 19 he/she will transfer to an appropriate home and community-based waiver for adults who meet the level of care requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD). Support coordinators must begin the transition process no less than 90 days prior to the recipient's 19th birthday and submit the transition plan to the LGE no less than 35 days prior to the recipient's 19th birthday.

Changing Support Coordination Agencies

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

- Complete the Freedom of Choice file transfer,
- Obtain the case record and authorized signature, and
- Inform the transferring support coordination agency.

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

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

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

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Other Support Coordination Responsibilities**Coordination of Family Support and Personal Care Services**

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

Assistance with Self-Direction Option

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

- Training recipients on their responsibilities as an employer,
- Completing required forms for participation in the self-direction option,
- Assisting with development of back-up service plan,
- Assisting with development of budget planning,
- Verifying potential employees meet program qualifications,
- Ensuring the recipient's needs are being met through services, and
- Monitoring the recipient's self-directed services face-to-face each quarter.

Reporting of Incidents, Accidents and Complaints

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

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SECTION 14.12: SELF-DIRECTION OPTION**PAGE(S) 2**

SELF-DIRECTION OPTION

Self-direction is a voluntary service delivery option which allows recipients to coordinate the delivery of Children's Choice Waiver services through an individual direct support professional rather than through a licensed, enrolled provider agency. The recipient becomes the employer of the direct service workers selected to provide the supports, and as the employer, the recipient or his/her authorized representative is responsible for recruiting, training, supervising and managing the direct service workers who have been hired.

A required component of this option is the use of a contracted fiscal/employer agent who will perform the recipient's employer-related payroll functions. A monthly administrative fee is deducted from the annual waiver service cap for the cost of the fiscal/employer agent. Support coordination services are also required for the development of the Plan of Care (POC), budget planning, ongoing evaluation of supports and services, and for organizing the various resources the recipient needs.

Recipients participating in this option must:

- Be a Children's Choice Waiver recipient,
- Understand the rights, risks, and responsibilities of managing his/her own care, and managing and using an individual budget, or if under 18 years of age or unable to make decisions independently, have a willing decision maker (authorized representative who is listed on the recipient's plan of care) who understands the rights, risks, and responsibilities of managing the care and supports of the recipient within the individualized budget,
- Be able to participate in this option without a lapse or decline in quality of care or an increased risk to his/her health and welfare,
- Adhere to the health and welfare safeguards identified by the team, including the application of a comprehensive monitoring strategy and risk assessment and management systems,
- Participate in the development and management of the approved budget, and
- Complete the mandatory training including rights and responsibilities of managing his/her own services and supports and individual budget offered by the support coordinator.

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

Termination of the Self-Direction Service Option

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

Voluntary Termination

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

Involuntary Termination

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

- The Office for Citizens with Developmental Disabilities determines that the health or welfare of the recipient is compromised by continued participation in the self-direction service delivery option.
- There is evidence that the recipient is no longer able to direct his/her care, and there is no authorized representative to direct the care.
- Over three payment cycles in a one year period, the recipient or the authorized representative:
 - places barriers to the payment of the salaries and related employment taxes of direct support staff,
 - fails to follow the approved budget,
 - fails to provide the required documentation of expenditures and related items, or
 - fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures.
- There is proof of misuse of public funds by the recipient or responsible representative.

DEVELOPMENTAL DISABILITY LAW

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

- a. A severe chronic disability of a person that:
 - Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.
 - Is manifested before the person reaches age twenty-two.
 - Is likely to continue indefinitely.
 - Results in substantial functional limitations in three or more of the following areas of major life activity:
 - Self-care.
 - Receptive and expressive language.
 - Learning.
 - Mobility.
 - Self-direction.
 - Capacity for independent living.
 - Economic self-sufficiency.
 - Is not attributed solely to mental illness.
 - Reflects the person’s need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

OR

- b. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria listed above later in life that may be considered to be a developmental disability.

GLOSSARY

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

Abuse (adult/elderly) – The infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (Louisiana Revised Statutes 15:1503)

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

- The infliction or attempted infliction, or as a result of inadequate supervision, the allowance or toleration of the infliction or attempted infliction of physical or mental injury upon the child by a parent or by any other person.
- The exploitation or overwork of a child by a parent or by any other person.
- The involvement of a child in any sexual act with a parent or with any other person, or the aiding or toleration by a parent or the caretaker of the child's sexual involvement with any other person, or the child's involvement in pornographic displays, or any other involvement of a child in sexual activity constituting a crime under the laws of this state. (Louisiana Children's Code, Article 603).

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

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

Appeal – A due process system of procedures which ensures that a recipient will be notified of and have an opportunity to contest a Department of Health and Hospital (DHH) decision.

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

Assessment – One or more processes that are used to obtain information about a person, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person requires waiver services as well as the development of the Plan of Care.

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Authorized Representative – A person designated by a recipient (by use of a designation form) to act on his/her behalf with respect to his/her services.

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

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

Claim – A request for payment for services rendered.

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

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

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

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

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

Department of Health and Hospitals (DHH) – The state agency responsible for administering the state’s Medicaid programs and other health and related services including public health, mental health, developmental disabilities, and addictive disorder services.

Developmental Disability – See Appendix A

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Diagnosis and Evaluation (D&E) – A process conducted by an appropriate professional to determine a person’s level of disability and to make recommendations for remediation.

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

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

Discharge – A recipient’s removal from the waiver for reasons established by OCDD.

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

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

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

Exploitation – The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of the person’s or disabled adult's power of attorney or guardianship for one's own profit or advantage. (Louisiana Revised Statutes 15:1503).

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation or abuse of legal or official authority.

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

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

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

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

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Home and Community-Based Services (HCBS) – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirement of an institutional level of care. It provides a collection of services through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services.

Intermediate Care Facility for People with Developmental Disabilities (ICF/DD) – A public or private facility that provides health and habilitation services to people with developmental disabilities. ICFs/DD have four or more beds and provide “active treatment” to their residents.

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

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

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

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

Licensure – A determination by the Medicaid Health Standards Section that a service provider agency meets the requirements of State law to provide services.

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

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

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

Medicaid Eligibility Determination (Form 90-L) – The form that is signed by a Louisiana licensed physician and used by Medicaid to establish a Level of Care (LOC). In the Children’s Choice waiver program, a recipient must meet an ICF/DD LOC in order to be offered a waiver opportunity.

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

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

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the recipient’s activities of daily living (La. R.S.15:1503).

Monitoring – The ongoing oversight of the provision of waiver services to ensure that they are furnished according to the recipient’s Plan of Care and effectively meet his/her needs.

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

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

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

Neglect (adult/elderly) – The failure of a care giver who is responsible for an adult's care or by other parties, or by the adult recipient’s action or inaction to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (Louisiana Revised Statutes 15:1503).

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

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

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

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

Person-Centered Planning – A Plan of Care process directed and led by the recipient or his/her authorized representative designed to identify his/her strengths, capacities, preferences, needs, and desired outcomes.

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

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

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

- What corrective actions will be accomplished for those waiver recipients found to have been affected by the deficient practice,
- How other recipients being provided services and support who have the potential to be affected by the deficient practice will be provided corrective care resulting from the Plan of Correction,
- The measures that will be put into place or the systemic changes that will be made to ensure that the deficient practice will not recur, and
- How the corrective measures will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place regarding the identified deficient practice.

Pre-certification Visit – The visit the OCDD Regional Waiver Supports and Services Office or Human Services District or Authority makes to the residence of the applicant, where at a minimum the applicant and, if appropriate, his/her representative(s) are in attendance in order to ensure that waiver planning and services, rights, responsibilities, methods of filing grievances and/or complaints, abuse/neglect and possible means of relief have been fully explained and that all parties are in agreement to move forward with waiver services.

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Prior and Post Authorization (PA) - The authorization for service delivery based on the recipient’s approved Plan of Care. Prior authorization must be obtained before any waiver services can be provided and post authorization must be approved before services delivered will be paid.

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

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

Quality Assurance/Quality Enhancement (QA/QE) Program: - A program that assesses and improves the equity, effectiveness and efficiency of waiver services in a fiscally responsible system with a focus on the promotion and attainment of independence, inclusion, individuality and productivity of persons receiving waiver services and accomplishes these goals through standardized and comprehensive evaluations, analyses and special studies.

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

Quality Management – The section within the OCDD whose responsibilities include the activities to promote the provision of effective services and supports on behalf of recipients and to assure their health and welfare. Quality management activities ensure that program standards and requirements are met.

Reassessment – A core element of services defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and redesigning the overall Plan of Care.

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

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible recipient.

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

Self-Neglect – The failure, either by the adult’s action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of

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healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected (Louisiana Revised Statutes 15:1503).

Sexual Abuse – Any sexual activity between a recipient and staff without regard to consent or injury; any non-consensual sexual activity between a recipient and another person, or any sexual activity between a recipient and another recipient, or any other person when the recipient is not competent to give consent. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent, request, suggestion, or encouragement by another person for the recipient to perform sex with any other person when recipient is not competent to refuse.

Single Point of Entry (SPOE) – The OCDD regional offices, Human Service Authorities and Human Service Districts where the entry point for all developmental disability services, including home and community-based waivers, is made.

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

Support Coordination –Case management services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational and other support services. Activities include assessment, Plan of Care development, service monitoring, and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources. Support coordination is also referred to as case management.

Support Coordinator – An person who is employed by a public or private entity compensated by the State of Louisiana through Medicaid State Plan Targeted Case management services to create and coordinate a comprehensive Plan of Care, which identifies all services and supports deemed necessary for the recipient to remain in the community as an alternative to institutionalization.

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

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

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

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

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

Waiver service – An approved service in a home and community-based waiver provided to an eligible recipient that is designed to supplement, not replace, the recipient’s natural supports.

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APPENDIX C – CONTACT INFORMATION

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CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Bureau of Health Services Financing - Health Standards Section	Office to contact to report changes that affect provider license	BHSF/Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 or (504) 342-0138 Fax: (225) 342-5292
Division of Administrative Law – Health and Hospitals Section	Office to contact to file an appeal request	Division of Administrative Law - Health and Hospitals Section P. O. Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 Fax: (225) 219-9823 Phone for oral appeals: (225) 342-5800
Provider Enrollment Section	Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer	Molina Medicaid Solutions Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370
Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information	Molina Medicaid Solutions Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783
Office of Community Services - Local Child Protection Hotline	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a recipient under the age of 18	Refer to the Department of Children and Family Services website at: http://www.dss.la.gov under the “Report Child Abuse/Neglect” link

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Office for Citizens with Developmental Disabilities		
Office Name	Physical Address	Phone/Fax
Central Office	638 N. Fourth St. Baton Rouge, LA 70802	(225) 342-0095 1-866-783-5553 Fax (225) 342-8823
Region 1 Metropolitan Human Services District	1010 Common St, 5 th floor New Orleans, LA 70113	(504) 599-0245 1-800-889-2975 Fax (504) 568-4660
Region 2 Capital Area Human Services District	4615 Government St., 2 nd floor Baton Rouge, LA 70806	(225) 925-1910 1-800-768-8824 Fax (225) 925-1966
Region 3 South Central Louisiana Human Services District	690 East 1 st Street Thibodaux, LA 70301	(985) 873-2085 1-800-861-0241 Fax (985) 449-5180
Region 4	214 Jefferson St, Suite 301 Lafayette, LA 70501	(337) 262-5610 1-800-648-1484 Fax (337) 262-5233
Region 5	3501 Fifth Ave, Suite C2 Lake Charles, LA 70605	(337) 475-8045 1-800-631-8810
Region 6	429 Murray Street, Suite B Alexandria, LA 71301	(318) 484-2347 1-800-640-7494 Fax (318) 484-2458
Region 7	3018 Old Minden Rd, Suite 1211 Bossier, LA 71112	(318) 741-7455 1-800-862-1409 Fax (318) 741-7445
Region 8	122 St. John St., Rm. 343 Monroe, LA 71201	(318) 362-3396 1-800-637-3113 Fax (318) 362-5306
Region 9 Florida Parishes Human Services Authority	21454 Koop Dr., Suite 2H Mandeville, LA 70471	(985) 871-8300 1-800-866-0806 Fax (985) 871-8303
Jefferson Parish Human Service Authority	3300 W. Esplanade Ave., Suite 213 Metairie, LA 70002	(504) 838-5357 Fax (504) 838-5400

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Office for Citizens with Developmental Disabilities Regional Waiver Offices		
Office Name	Physical Address	Phone/Fax
Region 1	1010 Common St, 5 th floor Suite 505 New Orleans, LA 70112	(504) 568-8564 Fax (504) 568-3373
Region 2	4615 Government Street Baton Rouge, LA 70806	(225) 925-6286 Fax (225) 925-7080
Region 3	690 East 1 st Street Thibodaux, LA 70301	(985) 449-4725 Fax (985) 449-4761
Region 4	214 Jefferson St, Suite 300 Lafayette, LA 70501	(337) 262-1612 1-800-648-1484 Fax (337) 262-1087
Region 5	3501 Fifth Ave, Suite C2 Lake Charles, LA 70607	(337) 475-8085 Fax (337-472-8005
Region 6	429 Murray Street, Suite A Alexandria, LA 71301	(318) 484-2310 Fax (318) 484-5666
Region 7	3018 Old Minden Rd, Suite 1211 Bossier, LA 71112	(318) 741-7486 Fax (318) 741-7487
Region 8	122 St. John St., Rm. 343 Monroe, LA 71201	(318) 362-3397 1-800-637-3113 Fax (318) 362-0406
Region 9	21454 Koop Dr., Suite 2B Mandeville, LA 70471	(985) 871-1352 Fax (985) 871-8346

APPENDIX D

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

The following forms can be obtained from <http://new.dhh.louisiana.gov/index.cfm/page/214>

- Environmental Accessibility Adaptation Flow Chart
- EPSDT Personal Care Services vs. Home Health Services
- Comparison Chart Louisiana Children's Choice Family Support – PCA & EPSDT-PCS
- Comparison Chart – Between Children's Choice and the New Opportunities Waiver
- Emergency Protocol for Tracking Location Before, During and After Hurricanes
- Request for Crisis Designation Flow Chart
- Comprehensive Plan of Care for Children's Choice Waiver
- Instructions for the CPOC Revision Request
- Children's Choice Comprehensive Plan of Care Revision Request
- Louisiana Children's Choice Request for Family Training
- Louisiana Children's Choice Waiver Request for Crisis Designation Form
- Environmental Accessibility Adaptation Job Completion Form
- Louisiana Children's Choice Waiver Request for Non-Crisis/Other Good Cause Criteria Designation
- Recipient's Consent for Authorized Representation
- Rights and Responsibilities for Individuals Requesting or Receiving Home and Community-Based Waiver Services

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

- The *Quality Enhancement Provider Handbook*. This document can be obtained from the DHH website at

<http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1470>

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

<http://new.dhh.louisiana.gov/index.cfm/page/137/n/140>

CHAPTER 14: CHILDREN’S CHOICE

APPENDIX E – BILLING CODES

**CHILDREN’S CHOICE WAIVER
SERVICES PROCEDURE CODES/RATES**

Effective January 1, 2014

**NOTE: Children’s Choice Waiver Cap = \$16,410
Services should not exceed waiver capped amount**

Provider Type	HCBS Waiver Service Description	HIPAA Code (effective 4/1/04)	Modifier	HIPAA Service Description	Units
45	Children’s Choice Support Coordination	9E001		Children’s Choice Support Coordination	Monthly \$125.00
03	Crisis Support	H2011		Crisis Intervention	15 minutes \$3.04
03	Family Support	S5125		Attendant Care Services	15 minutes \$3.50
03	Center Based Respite	T1005	HQ	Respite Care	15 minutes \$2.57
03	Family Training	S5111		Home Care Training-Family	Based on CPOC Funds Availability
03	Ramp-Home	S5165	U4	Home Modifications	
03	Bathroom Modifications	S5165	U5		
03	General Adaptations-Home	S5165			
03	Vehicle Lifts	T2039		Vehicle Modifications	
03	Specialized Medical Equipment and Supplies (Lifts)	Z0621		Medical Equipment and Supplies	
03	Specialized Medical Equipment and Supplies (Switches)	Z0622			
03	Specialized Medical Equipment and Supplies (Controls)	Z0623			
03	Specialized Medical Equipment and Supplies (Others)	Z0624			
03	Specialized Medical Equipment and Supplies (Routine maintenance and repair)	T2029	RP		
03	Crisis Support – 2 Children	H2011	UN	Crisis Intervention	15 minutes \$2.27
03	Family Support – 2 Children	S5125	UN	Attendant Care Services	15 minutes \$2.51
03	Crisis Support - Center Based	H2011	HQ	Crisis Intervention	15 minutes \$2.27

CHAPTER 14: CHILDREN’S CHOICE

APPENDIX E – BILLING CODES

Provider Type	HCBS Waiver Service Description	HIPAA Code (effective 4/1/04)	Modifier	HIPAA Service Description	Units
35/37	Aquatic Therapy	97113		Physical Therapy (Therapeutic Activities)	\$21.25/ 15 min \$85/ Hr.
35/37	Art Therapy	H2032		PT/OT Therapeutic Activities 1-3	\$13.75/ 15min/ \$55/hr.
35/37	Art Therapy	H2032	HQ	PT/OT Therapeutic Activities 4+	\$9.08/15min \$36.32/hr.
35/37	Music Therapy	G0176		PT/OT Therapeutic Activities 1-3	\$13.75/ 15min \$55/hr.
35/37	Music Therapy	G0176	HQ	PT/OT Therapeutic Activities 4+	\$9.08/15min \$36.32/hr.
35/37	Sensory Integration	97533		PT/OT Therapeutic Activities	\$23.92/15min \$95.68/hr.
35/37/39	Hippotherapy	S8590		PT/OT/ST Therapeutic Activities	\$21.25/15 min \$85/hr.
35/37/39	Therapeutic Horseback Riding	97799		PT/OT/ST Therapeutic Activities	\$9.38/15min \$37.52/hr.
31/AX	Applied Behavioral Analysis	90849		Psychologist (Therapeutic Behavioral Services)	\$29.56/15min \$118.24/ hr.
AW	Housing Stabilization	Z0648		Permanent Supportive Housing	\$15.11/15 Min. \$60.44/ hr.
AW	Housing Stabilization Transition	Z0649		Permanent Supportive Housing	\$15.11/15 Min. \$60.44/ hr.

The specified modifier is required for this HIPAA code.

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

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

Note: Planning of services is crucial for Children’s Choice Waiver participants, over utilization of services does not constitute necessity for Crisis Designation.

CHAPTER 14: CHILDREN'S CHOICE

APPENDIX F – CLAIMS FILING

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CLAIMS FILING

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

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

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

Paper claims should be submitted to:

Molina Medicaid Solutions
P.O. Box 91020
Baton Rouge, LA 70821

Services may be billed using:

- The rendering provider's individual provider number as the billing provider number for independently practicing providers, or
- 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 EDI Specifications located on the Louisiana Medicaid web site at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and a sample of a completed CMS-1500 claim form.
- Instructions for adjusting/voiding a claim and a sample of an adjusted CMS 1500 claim form.

CHAPTER 14: CHILDREN’S CHOICE

APPENDIX F – CLAIMS FILING

CMS 1500 (02/12) INSTRUCTIONS FOR HOME AND COMMUNITY – BASED WAIVER SERVICES

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 #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's I.D. Number	Required – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	Required – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	Situational – Enter the recipient's date of birth using six (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 recipient.	
4	Insured's Name	Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the recipient'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 NUCC USE		
9	Other Insured's Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	Situational – If recipient has no other coverage, leave blank. If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number. Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.
9b	RESERVED FOR NUCC USE	Leave Blank.	

CHAPTER 14: CHILDREN’S CHOICE

APPENDIX F – CLAIMS FILING

Locator #	Description	Instructions	Alerts
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 FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured’s Date of Birth 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	Insured’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	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabelled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

CHAPTER 14: CHILDREN’S CHOICE

APPENDIX F – CLAIMS FILING

Locator #	Description	Instructions	Alerts
21	ICD Ind. Diagnosis or Nature of Illness or Injury	<p>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.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required – Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD-10-CM codes will be announced at a later date.</p>
22	Resubmission Code	<p>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.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the “Original Ref. No.” portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).</p> <p>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.</p>
23	Prior Authorization Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	

CHAPTER 14: CHILDREN’S CHOICE

APPENDIX F – CLAIMS FILING

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). If a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference 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. #	Situational – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is required . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is optional .	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the recipient. 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.	

CHAPTER 14: CHILDREN’S CHOICE

APPENDIX F – CLAIMS FILING

Locator #	Description	Instructions	Alerts
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Rsvd for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional -- 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	Unlabelled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Optional.	
33b	Unlabelled	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 <u>must</u> appear on paper claims.

REMINDER: MAKE SURE “WAIVER” IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

A sample form is on the following page

CHAPTER 14: CHILDREN'S CHOICE

APPENDIX F – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA [] [] [] [] PICA [] [] [] []

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 M X F		5. PATIENT'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street)	
8. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State) YES NO	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
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		11. INSURED'S POLICY GROUP OR FECA NUMBER	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		a. INSURED'S DATE OF BIRTH MM DD YY M F	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		b. OTHER CLAIM ID (Designated by NUCC)	
15. OTHER DATE MM DD YY QUAL		c. INSURANCE PLAN NAME OR PROGRAM NAME	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY TO MM DD YY		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 7/a. QUAL 7/b. NPI		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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? \$ CHARGES YES NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. 3510 B. C. D. E. F. G. H. I. J. K. L.	
22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER 4123123123	
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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#		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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#	
1 03 31 14 03 31 14 12 S5125 UN A 90 00 30 NPI		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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#	
2 04 02 14 04 02 14 12 S5125 UN A 75 00 25 NPI		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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#	
3		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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#	
4		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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#	
5		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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#	
6		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. ICD9-CM (Rev. 10a) I. ID QUAL J. RENDERING PROVIDER ID.#	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO		28. TOTAL CHARGE \$ 165 00	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
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 Jane Doe DATE 4/5/14		32. SERVICE FACILITY LOCATION INFORMATION a. 1239876543 b. 1239876	
33. BILLING PROVIDER INFO & PH# (225) 555-4957 Here For You Waiver 200 Main St Any Town, LA 70000			

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

ADJUSTING/VOIDING CLAIMS

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

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

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

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

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

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

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

- 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.
- 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 Recipient/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid recipient 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 Remittance Advice 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.

CHAPTER 14: CHILDREN'S CHOICE

APPENDIX F – CLAIMS FILING

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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 Remittance Advice.

A sample form is on the following page

CHAPTER 14: CHILDREN'S CHOICE

APPENDIX F – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM ADJUSTMENT



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA										PICA																																																	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) X (Medicaid #) (ID#DoD#) (Member ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS										3. PATIENT'S BIRTH DATE MM DD YY 07 31 72					SEX M X F					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street) CITY STATE										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street) CITY STATE																																							
8. RESERVED FOR NUCC USE										8. RESERVED FOR NUCC USE										8. RESERVED FOR NUCC USE																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.																																							
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										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 71b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										20. OUTSIDE LAB? \$ CHARGES YES NO																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 9 A. 3510 B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO. A 00 4094198765400																																							
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID QUAL J. RENDERING PROVIDER ID. #										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID QUAL J. RENDERING PROVIDER ID. #										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID QUAL J. RENDERING PROVIDER ID. #																																							
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25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT AS SIGNMENT? (For gov. claims only) X YES NO										28. TOTAL CHARGE \$ 75 00										29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe DATE 4/9/14										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH# (225) 555-4957 Here For You Waiver 200 Main St Any Town, LA 70000																																							
SIGNED Jane Doe DATE 4/9/14										a. 1239876543										b. 1239876																																							

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