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

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OVERVIEW

The Adult Day Health Care (ADHC) Waiver is a Medicaid Home and Community-Based Services Waiver program that expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities.

This provider manual 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 Department of Health and Hospitals (DHH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

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

This manual chapter is intended to provide an ADHC Waiver provider with the information necessary 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 department rules.

The DHH Bureau of Health Services Financing (BHSF) and the DHH Office of Aging and Adult Services (OAAS) are responsible for assuring provider compliance with these regulations.

Oversight of the services offered through the Adult Day Health Care Waiver is conducted through licensure compliance and program monitoring. The DHH Bureau of Health Services Financing (BHSF) and the DHH Office of Aging and Adult Services (OAAS) are responsible for assuring provider compliance with these regulations.

Waiver services to be provided are specified in the Plan of Care which is written by the support coordinator based on input from the planning team. The planning team is comprised of the recipient, the support coordinator, and in accordance with the recipient’s preferences, members of the family/natural support system, appropriate professionals and others whom the recipient chooses. The Plan of Care contains all services and activities involving the recipient, non-waiver as well as waiver services. Recipients are to receive those waiver services included in the Plan of Care and approved by the appropriate support coordination designee or OAAS regional office (as applicable). Notification of approved services is forwarded to the provider by the support coordinator, and the contracted data management agency issues prior authorization to the providers based on the approved Plan of Care.
The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the Centers for Medicare and Medicaid Services.
COVERED SERVICES

This section provides information about the services that are covered in the Adult Day Health Care (ADHC) Waiver program. For the purpose of this policy, when reference is made to “individual” or “recipient”, this includes that person’s responsible representative(s), legal guardian(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

Support Coordination

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

• Intake;
• Assessment;
• Plan of care development and revision;
• Linkage to direct services and other resources;
• Coordination of multiple services among multiple providers;
• Monitoring/follow-up;
• Reassessment;
• Evaluation and re-evaluation of level of care and need for waiver services;
• Ongoing assessment and mitigation of health, behavioral and personal safety risk;
• Responding to recipient crisis;
• Critical incident management; and
• Transition/discharge and closure.
Providers of support coordination shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by recipients in receiving direct services.

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

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

**Standards**

Providers of ADHC Waiver support coordination must be:

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

**Reimbursement**

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

**Transition Intensive Support Coordination**

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

Support coordinators shall comply with all of the requirements described above under the Support Coordination section. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the recipient’s approved POC.

**Standards**

Providers of ADHC Waiver TISC must be:

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

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

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

Service Limitations

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

Reimbursement

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

Transition Services

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

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

Transition Services include the following:

- Security deposits that are required to obtain a lease on an apartment or house;
• Specific set-up fees or deposits for:
  • Telephone;
  • Electricity;
  • Gas;
  • Water; and
  • Other such necessary housing start-up fees and deposits.

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

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

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

Standards

Providers of ADHC Waiver transition services must be:
Certified by LDH to operate a support coordination agency;

Meet the requirements as set forth in the rule for OAAS Home and Community-Based Services Waivers, Support Coordination Standards for Participation;

Sign a performance agreement with OAAS;

Assure staff attends all training mandated by OAAS;

Enroll as a Medicaid provider of support coordination services in all regions in which it intends to provide services;

Comply with all LDH and OAAS policies and procedures; and

Be listed as the provider of choice on the FOC form.

Service Exclusions

Transition services do not include the following:

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

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

Service Limitations

There is a $1,500 lifetime maximum limit per individual. Services must be prior approved by the OAAS regional office or its designee and require PA.

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

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

Reimbursement

Payment shall not be authorized until the OAAS regional office, or its designee gives final POC approval upon receipt of the “Decision Notice” form from the Medicaid office.

When the final approval is issued, the data management contractor is notified to set up a transition service expense record in the database for the individual and to release the authorization. The support coordination agency is notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

The OAAS regional office, or its designee, shall maintain documentation, including each individual’s “OAAS Transition Services Form” (TSF) with original receipts and copies of canceled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes. (See Appendix B for information about this form)

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

NOTE: If the individual is not approved for ADHC Waiver services and/or does not transition, but transition service items were purchased, the OAAS regional office must notify the OAAS state office to allow for possible reimbursement.

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

Adult Day Health Care Service

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

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

- Assistance with activities of daily living (toileting, grooming, eating, ambulation, etc.);
- Health and nutrition counseling;
- Individualized daily exercise program;
- Individualized goal-directed recreation program;
- Daily health education;
- Medical care management;
- One nutritionally-balanced hot meal and a minimum of two snacks served each day.

**NOTE:** A provider may serve breakfast in place of a mid-morning snack. Also, providers must allow flexibility with their food and dining options to reasonably accommodate participants’ expressed needs and preferences.

- Nursing services that include the following individualized health services:
  - Monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;
  - Administering medications and treatments in accordance with physicians’ orders;
  - Monitoring self-administration of medications while the recipient is at the ADHC center; and
  - Serving as a liaison between the recipient and medical resources including the treating physician.

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

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

NOTE: If transportation services that are prescribed in any recipient’s approved ISP are not provided by the ADHC center, the center’s reimbursement rate shall be reduced accordingly.

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

Standards

Providers must be licensed by the LDH Health Standards Section (HSS) as an ADHC provider, enrolled in Medicaid as an ADHC provider and must be listed on the FOC form prior to providing ADHC services.

NOTE: It is permissible for an ADHC center to serve a person residing outside of the ADHC’s licensed region when there are no other licensed HCBS providers in the participant’s service area with the capacity to provide the required services. The provider must submit a written request to HSS specific to the participant for which exception is being requested and include the reasons prior to the provision of services.

Service Exclusions

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

ADHC Waiver recipients must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. The assigned support coordinator, based upon guidance provided by OAAS, must approve exceptions for extenuating circumstances.

NOTE: It is allowable for an ADHC to refuse services to someone because the individual resides outside of the ADHC’s established limited mileage radius for transportation to and from the center as long as this transportation policy is approved by HSS. In such an instance, providing transportation to/from the facility is not a requirement; however, if transportation is provided, all rules and requirements must be met.
Service Limitations

These services must be provided in the ADHC center that has been chosen by the recipient.

ADHC services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours per week (exclusive of transportation time to and from the ADHC center), as specified in the recipient’s POC and ADHC individualized service plan (ISP).

Reimbursement for these services requires PA.

Reimbursement

Payment will not be authorized until the OAAS regional office, or its designee, gives final POC approval.

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

The use of the Electronic Visit Verification (EVV) system is mandatory for Adult Day Health Care Services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by BHSF and OAAS. Adult Day Health Care transportation is exempt from this mandatory requirement.

Hospice and Waiver Services

Recipients who elect hospice services may choose to elect ADHC Waiver and hospice services concurrently. The hospice provider and support coordination agency must coordinate ADHC Waiver and hospice services when developing the recipient’s POC. All core hospice services must be provided in conjunction with ADHC Waiver services. When electing both services, the hospice provider must develop the POC with the recipient, the recipient’s care giver and the support coordination agency. The POC must clearly and specifically detail the ADHC Waiver and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the recipient’s daily needs are being met. This will involve coordinating services where the recipient may receive services each day of the week.

The hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral
care, drugs and biologicals, therapies, medical appliances and supplies, and counseling.

Once the hospice program requirements are met, ADHC Waiver Services and LT-PCS (if applicable) can be utilized for those personal care tasks with which the recipient requires assistance.
RECIPIENT REQUIREMENTS

The Adult Day Health Care (ADHC) Waiver program is only available to individuals who meet all the following criteria:

- Medicaid financial eligibility,
- Age 65 years or older, OR 22 through 64 years of age with a physical disability that meets Medicaid standards or the social Security Administration’s disability criteria,
- Nursing facility level of care requirements,
- Name on the Request for Services Registry for the ADHC Waiver, and
- A Plan of Care sufficient to:
  - Assure the health and welfare of the waiver applicant in order to be approved for waiver participation or continued participation, and
  - Justify that the ADHC Waiver services are appropriate, cost effective and represent the least restrictive environment for the individual.

ADHC Waiver recipients must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. The assigned support coordinator, based upon guidance provided by OAAS, must approve exceptions for extenuating circumstances.

NOTE: An individual may only be certified to receive services from one home and community-based waiver at a time.

Request for Services Registry

The Department of Health and Hospitals (DHH) is responsible for the Request for Services Registry (RFSR), hereafter referred to as “the registry,” for the ADHC Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll-free telephone number which is maintained by the Office of Aging and Adult Services (OAAS).

Individuals will be screened to determine whether they meet nursing facility level of care. Only individuals who meet this criterion will be added to the registry. The individual’s name is placed on the registry in request date order.

ADHC Waiver opportunities shall be offered to individuals on the registry according to priority
groups. The following groups shall have priority for ADHC Waiver opportunities in the order listed:

- Individuals with substantiated cases of abuse or neglect with Adult Protective Services (APS) or Elderly Protective Services (EPS) and who, absent ADHC Waiver services would require institutional placement to prevent further abuse and neglect,

- Individuals who have been discharged after a hospitalization within the past 30 days that involved a stay of at least one night,

- Individuals admitted to a nursing facility who are approved for a stay of more than 90 days; and

- All other eligible individuals on the RFSR, by date of first request for services.

If an applicant is determined to be ineligible for any reason at the time an offer is made, the next individual on the registry, based on the above stated priority group, is notified and the process continues until an individual is determined eligible. An ADHC Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

**Admission Denial or Discharge Criteria**

Failure of the individual to cooperate in the eligibility determination process or to meet any of the following criteria will result in denial of admission to/discharge from the ADHC Waiver:

- The individual does not meet the criteria for Medicaid financial eligibility,

- The individual does not meet the criteria for a nursing facility level of care,

- The recipient resides in another state or has a change of residence to another state,

- Continuity of services is interrupted as a result of the recipient not receiving and/or refusing ADHC Waiver services (exclusive of support coordination services) for a period of 30 consecutive days,

  **Note:** Continuity of services will not apply when interruptions are due to a recipient being admitted to a rehabilitation hospital or nursing facility so long as the stay does not exceed 90 consecutive days.

- The health and welfare of the individual cannot be reasonably assured through the
provision of the ADHC Waiver services within the individual’s cost effectiveness,

- The individual fails to cooperate in the eligibility determination process or in the performance of the Plan of Care,

- It is not cost effective to serve the individual in the ADHC Waiver,

- The recipient fails to attend the ADHC center for a minimum of 36 days per calendar quarter, or

- The recipient fails to maintain a safe home environment.

Involuntary discharge/transfer from the waiver may occur for one of the following:

- Medical protection or the well-being of the individual or others,

- Emergency situation (i.e., fire or weather related damage),

- Health or welfare of the recipient is threatened, or

- An inability of the ADHC provider to furnish the services indicated in the recipient’s Plan of Care after documented reasonable accommodations have failed.
RECIPIENT RIGHTS AND RESPONSIBILITIES

Recipients have specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid 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 on recipient rights.

Freedom of Choice of Program

Individuals who have been offered waiver services have the freedom to select between institutional care services and community-based services. They have the responsibility to participate in the evaluation process which includes providing medical and other pertinent information or assisting in obtaining it for use in the person-centered planning process and certification for services. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

Freedom of Choice of Providers

Recipients have the freedom of choice to select their providers. Recipients may make provider changes based on the following schedule:

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<th>With Good Cause</th>
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<tr>
<td>Transition Intensive Support Coordination</td>
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<tr>
<td>Adult Day Health Care (ADHC)</td>
<td>Every 6 months</td>
<td>Any time</td>
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<tr>
<td>Transition Service</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
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NOTE: The change is based on a calendar year with the change effective beginning the first day of the following quarter.

Support coordinators will provide recipients their choice of ADHC providers and help arrange and coordinate the services on the Plan of Care.

The Office of Aging and Adult Services (OAAS), or its designee will provide recipients with their choice of support coordination providers.
Adequacy of Care

All recipients in Louisiana’s home and community-based waiver programs have the right to choose and receive the services necessary to support them to live in a community setting. Services are arranged and coordinated through the support coordination system and approval by the OAAS regional office or its designee. Administrative limits are placed on some services according to the waiver that is authorized by the Center for Medicare and Medicaid Services.

Recipients have the responsibility to request only those services they need and not request excess services, or services for the convenience of providers or support coordinators. Units of service are not “saved up”. The services are certified as medically necessary and are revised on the Plan of Care as each recipient’s needs change.

Participation in Care

Each recipient shall participate in person-centered planning meetings and any other meeting involving decisions about services and supports to be provided as part of the waiver process. Person-centered planning will be utilized in developing all services and supports to meet the 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. The recipient shall report any service need change to his/her support coordinator and service provider(s).

Changes in the amount of services must be requested by the recipient and submitted to the support coordinator at least 14 calendar days before taking effect, except in emergencies. Providers may not initiate requests for change/adjustment of service(s), or modify the Plan of Care, without the participation and consent of the recipient. These changes must be approved by the OAAS regional office or its designee.

Voluntary Participation

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 the ADHC Waiver is to provide community-based services to individuals who would otherwise require care in a nursing facility. Providers must reasonably 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.
Quality of Care

Each recipient of home and community-based waiver services has the right to receive services from provider agency employees who have been trained and are qualified to provide them. In cases where services are not delivered according to the approved Plan of Care or there is abuse or neglect on the part of the service 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 they may not violate the rights of other recipients.

Civil Rights

Providers shall operate in accordance with Title 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 individuals are accepted and 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 their providers by not requesting services which in any way violate these laws.

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the ADHC Waiver recipients. In order to maintain eligibility, recipients have the responsibility to inform BHSF of changes in their income, address, and living situation.

The OAAS or its designee is responsible for approving level of care and medical certification. In order to maintain this certification, recipients have the responsibility to inform the OAAS, through their support coordinator, of any significant changes which affects their service needs. Providers may not approve or deny the recipient’s level of care or waiver certification.

Grievances/Fair Hearings

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.

All support coordination/direct service providers shall have grievance procedures through which recipients may grieve the supports or services they receive. Recipients must be advised of their rights to a fair hearing and the process for an appeal through the Division of Administrative Law. In the event of a fair hearing, a representative of the service provider and support coordination agency shall participate by telephone or, if requested, appear in person and participate in the
proceedings.

An appeal by the recipient may be filed at the local Medicaid Office or with the Division of Administrative Law. (See Appendix A for contact information)

**Complaint/Help Lines**

Toll-free numbers are available to provide waiver assistance, clarification of waiver services, and reporting complaints regarding waiver services including reports of abuse, neglect and exploitation. (See Appendix A for contact information)

These toll-free numbers are accessible within the State of Louisiana.

**Rights and Responsibilities Form**

The support coordinator is responsible for reviewing the recipient’s rights and responsibilities with the recipient and his/her personal representative as part of the initial intake process and at least annually thereafter. (See Appendix B for information on accessing the Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Home and Community-Based Waiver Services (HCBWS) form)
SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Adult Day Health Care (ADHC) Waiver opportunity or an existing opportunity is vacated, the individual who meets criteria for the priority group, or whose date is reached on the Request for Services Registry (RFSR), shall receive a written notice indicating that a waiver opportunity is available. The applicant will receive a waiver offer packet that includes a Waiver Decision Form and a Support Coordination Agency Freedom of Choice form.

The applicant must complete and return the packet to indicate interest in receiving an ADHC Waiver opportunity and to determine if he/she meets the level of care and/or any additional program requirements.

If the applicant meets the preliminary level of care and/or additional program requirements, he/she will be linked to a support coordination provider. A support coordinator will be assigned to conduct an in-home assessment with the applicant and inform him/her of all available services. The support coordinator shall also assist the applicant as needed with the financial eligibility process conducted by the Medicaid parish office.

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. The following must be addressed in the Plan of Care:

- 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 waiver service, and
- The total cost of waiver services covered by the Plan of Care.

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 Plan of Care. The support coordinator will have the recipient or responsible representative complete the provider Freedom of Choice (FOC) form. FOC will be offered 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 necessary services,
• Securing from selected providers a commitment to provide services, assessments and/or plans (based on the providers specific type of service), and

• Forwarding the Plan of Care packet to the Office of Aging and Adult Services (OAAS) regional office or its designee, as applicable for review and approval following the established protocol.

NOTE: The authorization to provide service is contingent upon approval by the OAAS regional office or its designee.

Prior Authorization

All services under the ADHC Waiver must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid recipient by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all edits contained within the claims payment process, the 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.

PA revolves around the Plan of Care document, which means that only the service codes and units specified in the approved Plan of Care will be prior authorized. Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The service provider is responsible for the following activities:

• Developing an Individual Service Plan (ISP) in accordance with the approved Plan of Care.

• Checking prior authorizations to verify that all prior authorizations for services match the approved services in the recipient’s Plan of Care. Any mistakes must be immediately corrected to match the approved services in the Plan of Care.

• Verifying that the case record documentation is completed correctly and that services were delivered according to the recipient’s approved Plan of Care prior to billing for the service.
• Verifying that services were documented as evidenced by timesheets, attendance records, progress notes and progress summaries and are within the approved service limits as identified in the recipient’s Plan of Care prior to billing for the service.

• Completing data entry into the direct service provider data system, Louisiana Services Tracking (LAST) system.

• 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 delivered to the recipient and are approved in the recipient’s Plan of Care.

• Reconciling all remittance advices issued by the Department of Health and Hospitals (DHH) fiscal intermediary with each payment.

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

NOTE: Service providers have one-year timely filing billing requirement under Medicaid regulations.

Support Coordination

Authorization for support coordination service is issued by the data management contractor through two authorization periods for the Plan of Care year. A service unit is one month and each authorization covers a five to seven month period, or five to seven service units. At the end of the month, after the support coordination provider fulfills the service requirements and inputs the required documentation in the Case Management Information System (CMIS), the data contractor will release one service unit of the PA.

Transition Intensive Support Coordination

Authorization for transition intensive support coordination is issued upon receipt of the Plan of Care (provisional or initial) and the “Request for Payment/Override Form” that have been approved by the OAAS regional office. (See Appendix B for a copy of this form)

A service unit is one month. The authorization includes a unit of service for each month with a maximum of six units of service per authorization. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the CMIS, the data contractor will release one service unit of the PA.
NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances as determined and approved by OAAS.

Transition Services

Only one authorization for transition services is issued. The authorization period is the effective date of the Plan of Care or revision request through the Plan of Care end date. After the approved purchases are made, the Plan of Care (provisional, initial or revised) that includes the transition services, the receipts for the purchases and the “Transition Service Expense and Planning Approval (TSEPA) Form” are sent to the data management contractor. (See Appendix B for a copy of this form)

The data management contractor simultaneously issues and releases the authorization to the support coordination provider upon receipt of complete and accurate information. The support coordination provider is responsible for reimbursing the purchaser (recipient, family, provider, own agency, etc.) upon receipt of reimbursement.

Adult Day Health Care Services

Adult Day Health Care Services are assigned a PA number for the year. Approved units of service are calculated on a weekly basis to the provider and must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning at 12:00 a.m. Sunday and ending at 12:00 a.m. the following Sunday. Payment for services is capped for each week.

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

Post Authorization

Some services require post authorization before the provider is able to bill for services rendered. 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 units of service. Once post authorization is granted, the service provider may bill the DHH fiscal intermediary for the appropriate units of service.

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

All requests for changes in services and/or service hours must be made by the recipient or his/her responsible representative.

Changing Support Coordination Providers

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

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

After the recipient has selected and been linked by the data contractor to a new support coordination provider, the new provider must inform the transferring provider and complete the FOC file transfer. The new provider must obtain the case record and authorized signature, and inform the transferring provider.

Upon receipt of the completed form, the transferring provider must have provided copies of the following information to the new provider:

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

NOTE: The new support coordination provider must bear the cost of copying which cannot exceed the community’s competitive copying rate. If the new provider does not receive the information in a timely fashion, the appropriate OAAS regional office should be contacted for assistance.
The transferring support coordination provider shall provide services up to the transfer of records and is eligible to bill for support coordination services for the month in which the dated notification is received (transfer of records) by the receiving provider. In the month the transfer occurs, the receiving provider 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. Immediately after the transfer of records, the receiving provider must submit the required documentation to the data contractor to obtain prior authorization.

Prior Authorization for New Support Coordination Providers

A new PA number will be issued to the new support coordination provider with an effective starting date as the first day of the first full calendar month following the date of the transfer of the records. The transferring provider’s PA number will expire on the date of the transfer of the records.

The OAAS or its agent will not backdate the new PA period to the first day of the calendar month in which the FOC and transfer of records are completed. If the new support coordination provider receives the records and admits a recipient in the middle of a month, they cannot bill for services until the first day of the next month.

Changing ADHC Providers

Recipients may change ADHC providers once every six months. ADHC providers may be changed for good cause at any time as approved by the OAAS regional office or its designee.

Good cause is defined as:

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

Recipients must contact their support coordinator to change ADHC providers.
The support coordinator will provide the recipient with the current FOC list of ADHC providers. Once a new provider has been selected, the support coordinator will ensure the new provider is notified of the request. With written consent from the recipient, both the transferring and receiving providers share responsibility for ensuring the exchange of medical and program information which includes:

- 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 Individualized Service Plan,
- Current assessments upon which the Individualized Service Plan is based,
- A summary of the recipient’s behavioral, social, health and nutritional status,
- Records tracking recipient’s progress towards Individualized Service Plan goals and objectives,
- Documentation of the amount of authorized services remaining in the Plan of Care, including direct service case record documentation, and
- Documentation of exit interview.

The support coordinator will facilitate the transfer of the above referenced information to the receiving ADHC provider and forward copies of the following to the new ADHC provider:

- Most current Plan of Care,
- Current assessments on which the Plan of Care is based,
- Number of services used in the calendar year, and
- All other waiver documents necessary for the new ADHC provider to begin providing services.

The new ADHC provider must bear the cost of copying, which cannot exceed the community’s competitive copying rate.
Prior Authorization for New ADHC Providers

The support coordinator will complete a Plan of Care revision form that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the Plan of Care revision. The transferring provider’s PA number will expire on the end date as indicated on the Plan of Care revision.
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, including licensure, as established by state laws and rules promulgated by the Louisiana Department of Health (LDH);

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

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

Providers 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.

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) and R.S. 40:1203.1 et seq. Providers are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must take all reasonable steps to determine whether applicants for employment have histories indicating involvement in 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.

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

Providers must participate in the initial training for prior authorization (PA) 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 available computer equipment and software necessary to participate in PA
and data collection.

All brochures provided by the Adult Day Health Care (ADHC) provider must be approved by the Office of Aging and Adult Services (OAAS) prior to use.

Waiver services are to be provided strictly in accordance with the provisions of the approved plan of care. ADHC providers and support coordination agencies are obligated to report changes to LDH that could affect the recipient’s eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

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

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

ADHC providers are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the recipient and completing an incident report. The incident report shall be submitted to OAAS, or its designee, with the specified requirements. (See Appendix B for information on accessing the *OAAS Critical Incident Reporting Policies and Procedures* manual.)

Each ADHC Waiver provider shall complete the LDH approved cost report and submit the cost report(s) to the designated LDH contractor no later than five (5) months after the state fiscal year ends (June 30). (See Appendix A to obtain web address for additional information.)
Licensure and Specific Provider/ Agency Requirements

Providers, or agencies, must meet licensure and/or certification and other additional requirements as outlined below:

**Support Coordination, Transition Intensive Support Coordination and Transition Services**

<table>
<thead>
<tr>
<th>Provided by a <strong>support coordination agency</strong> who:</th>
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<tbody>
<tr>
<td>• Is certified to provide support coordination services;</td>
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<tr>
<td>• Has signed the OAAS Performance Agreement;</td>
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<tr>
<td>• Has purchased a Citrix account through OAAS;</td>
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<tr>
<td>• Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training;</td>
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<tr>
<td>• Has a brochure that has been approved by OAAS;</td>
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<tr>
<td>• Has submitted a completed OAAS agency contact information form to OAAS; and</td>
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<tr>
<td>• Has enrolled as a Medicaid support coordination agency.</td>
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**Adult Day Health Care**

<table>
<thead>
<tr>
<th>Provided by an <strong>ADHC provider</strong> who:</th>
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<tr>
<td>• Is licensed according to Louisiana Revised Statute 40:2120.47; and</td>
</tr>
<tr>
<td>• Has enrolled in Medicaid as an ADHC provider.</td>
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**NOTE:** Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code.

**Provider Responsibilities**

Providers of ADHC Waiver services must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision and coverage as set forth by their respective licensing authorities and in accordance with all applicable LDH and OAAS rules and policies.

Providers shall not refuse to serve any recipient who chooses their agency, unless there is documentation to support an inability to meet the recipient’s health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services.
Refusal to serve a recipient must be put in writing by the provider to the support coordinator and the recipient. This written notice must provide a detailed explanation as to why the provider is unable to provide services to the recipient. Upon receipt of this written documentation, the support coordinator is to forward the notice to the OAAS regional office for approval/refusal.

Providers shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to harassment, intimidation or threats against the recipient or members of the recipient’s informal network, support coordination staff or employees of LDH.

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

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

- The provider shall provide written notice to the recipient, a family member and/or the responsible representative, if known, and the support coordinator at least 30 calendar days prior to the transfer or the discharge;
- Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the recipient understands;
- A copy of the written discharge/transfer notice shall be put in the recipient’s record;
- When the safety or health of recipients or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge;
- The written notice shall include the following:
  - A reason for the transfer or discharge;
  - The effective date of the transfer or discharge;
  - An explanation of a recipient’s right to personal and/or third party representation at all stages of the transfer or discharge process;
  - Contact information for the Advocacy Center;
  - Names of provider personnel available to assist the recipient and family in decision making and transfer arrangements;
  - The date, time and place for the discharge planning conference;
  - A statement regarding the recipient’s appeal rights;
  - The name of the director, current address and telephone number of the
Division of Administrative Law; and

- A statement regarding the recipient’s right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

- Developing a written report detailing the circumstances leading to any discharge;

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

- Developing a discharge plan that specifies the recipient’s needed supports and the resources available to him/her after discharge and includes options that will provide reasonable assurance that the recipient will be transferred or discharged to a setting that can be expected to meet his/her needs;

- Providing all services required and contained in the final update of the service plan and in the transfer or discharge plan up until the transfer or discharge;

- Coordinating and consulting with the receiving center or other program (if applicable) to discuss the recipient’s needs as warranted; and

- Preparing and submitting to the receiving center or program an updated discharge service plan and written discharge summary of the recipient’s needs and health that shall include, at a minimum:
  
  - medical diagnoses;
  - medication and treatment history/regimen (current physician’s orders);
  - functional needs (inabilities);
  - any special equipment utilized (dentures, ambulatory aids, eyeglasses, etc.)
  - social data and needs;
  - financial resources; and
  - any other information which would enable the receiving ADHC center/caregiver(s) to provide the continued necessary care without interruption.
Support Coordination Agencies

Support coordination agencies must meet all of the requirements included in the OAAS support coordination performance agreement, the support coordination standards for participation, and any additional criteria outlined in this manual chapter.

Providers of support coordination 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 at intake or at the first meeting with the recipient.

Providers of support coordination must have brochures that provide information about their agency’s experience, including the provider’s toll-free number and the OAAS toll-free information number.

Providers of support coordination shall furnish information and assistance to recipients in directing and managing their services.

Support coordinators must provide the recipient’s approved plan of care to the ADHC provider in a timely manner.

ADHC Providers

ADHC provider agencies must have written policy and procedure manuals that include, but are not limited to the following:

- Training policy that includes staff orientation in safety and emergency procedures as stipulated by LDH licensing and certification rules and regulations;

- Employees must possess direct care abilities, skills and knowledge 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;

• Information about abuse and neglect as defined by LDH regulations and state and federal laws; and

• Policies and procedures for the management of voluntary and involuntary discharges/transfers from their agency.

ADHC providers must provide the recipient’s approved individualized service plan to the support coordinator in a timely manner.

An ADHC Waiver recipient must attend the ADHC center a minimum of 36 days per calendar quarter, absent extenuating circumstances. An ADHC provider is not allowed to impose that recipients attend a minimum number of days per week. A recipient’s repeated failure to attend as specified in the plan of care (POC) may warrant a revision to the POC or possibly a discharge from the waiver. ADHC providers should notify the recipient’s support coordinator when a recipient routinely fails to attend the ADHC as specified.

When an ADHC provider reaches licensed capacity, the OAAS regional office should be notified immediately. The provider’s name will be removed from the ADHC FOC form until they notify the OAAS regional office that they are able to admit new recipients.

An ADHC provider shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the ADHC’s responsibilities are carried out and that the following functions are adequately performed:

• Administrative;

• Fiscal;

• Clerical;

• Housekeeping, maintenance and food service;

• Direct services;

• Supervision;

• Record-keeping and reporting;
• Social services; and
• Ancillary services.

The ADHC provider shall ensure the following:

• All non-licensed direct care staff members meet the minimum, mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-2179.1;

• All staff members are properly certified and/or licensed as legally required;

• An adequate number of qualified direct service staff is present with recipients as necessary to ensure the health, safety and well-being of recipients;

• Procedures are established to assure adequate communication among staff in order to provide continuity of services to recipients to include:
  • Regular review of individual and aggregate problems of recipients, including actions taken to resolve these problems;
  • Sharing daily information, noting unusual circumstances and other information requiring continued action by staff; and
  • Maintenance of all accidents, injuries and incident records related to recipients;

• Employees working with recipients have access to information from case records necessary for effective performance of the employees’ assigned tasks;

• A staff member who has knowledge of and can apply first aid and who is certified in CPR must be in the ADHC at all times;

• A staff member shall be designated to supervise the ADHC in the absence of the director;

• A written plan of emergency and safety procedures that includes training staff on their duties when responding to emergencies and evacuating recipients to safe or sheltered areas;
CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

SECTION 9.5: PROVIDER REQUIREMENTS

- All furnishings and equipment must be:
  - Kept clean;
  - In good repair; and
  - Appropriate for use by the recipients in terms of comfort and safety.

Changes

Changes in the following areas are to be reported in writing to HSS, OAAS and the fiscal intermediary’s Provider Enrollment Section at least ten (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.

When a provider closes or decides to no longer participate in the Medicaid program, the provider must provide a 30-day written advance notice to recipients and their responsible representatives, support coordination agencies and LDH prior to discontinuing service.
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 Louisiana Department of Health’s (LDH) administrative region where the recipient resides. The provider must have sufficient space, facilities and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the recipient served and the provision of services.

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

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 are answered;

  OR

- Six 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 and copies of the required documents transferred to the new agency.

Confidentiality and Protection of Records

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

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, the 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 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
- Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

A provider must, upon request, make available information in the case records to the recipient or 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, that information may be withheld from the recipient except under court order.

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

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

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

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.

**NOTE:** 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 LDH or its designee and appropriate state and federal personnel at all reasonable times. Providers must
always safeguard the confidentiality of recipient information.

Recipient Records

Providers must have a separate written record for each recipient served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, support coordination agencies and service providers must have adequate documentation of services offered and provided to recipients they serve. This documentation is an on-going chronology of activities undertaken on behalf of the recipient.

See below for specific information regarding documentation of the following services:

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<thead>
<tr>
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ADULT DAY HEALTH CARE SERVICES

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<td>Progress Summary</td>
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<td>Complete within 14 days of discharge.</td>
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Organization of Records, Record Entries and Corrections

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

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

- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title of the person making the entry;
- The full date of documentation; and
- Reviewed by the supervisor, if required.

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.**
Progress Notes and Summaries

Progress notes are the means of summarizing activities, observations and the progress made toward meeting service goals in the recipient’s plan of care (POC).

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 progress and service needs. 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.

Progress notes and summaries must:

- Indicate who was contacted, where contact occurred, and what activity occurred;
- Record activities and actions taken, by whom, and progress made; and indicate how the recipient is progressing toward the personal outcomes in the POC and individual service plan (ISP), as applicable;
- Document delivery of services identified on the POC and the ISP, as applicable;
- Document any deviation from the POC;
- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and POC and ISP change, as applicable;
- Be legible (including signature) and include the functional title of the person making the entry and date;
- Be complete and updated in the record in the time specified;
- Be complete and updated by the supervisor (if applicable) in the record as a progress summary at the time specified;
- Be recorded more frequently when there is frequent activity or when significant changes occur in the recipient's service needs and progress;
- Be signed by the person providing the services; and
- Be entered in the recipient’s record when a case is transferred or closed.
Progress notes and summaries must be documented in narrative format that reflects delivery of each service and elaborates on the activity of the contact. The progress notes and summaries must summarize all activities for a specified period which addresses significant activities and progress/lack of progress toward the desired outcomes and changes that may impact the POC and/or ISP and the needs of the recipient. Progress notes and summaries must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current POC and ISP (if applicable), allow for sufficient information for use by support coordinators, other direct service workers or their supervisors, and allow for evaluation of activities by program monitors.

Progress notes and summaries must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note.

NOTE: General terms and phrases such as “called the recipient”, “supported recipient”, or “assisted recipient” are not sufficient and do not reflect adequate content. Check lists alone are not adequate documentation.

Discharge Summary for Transfers and Closures

A discharge summary details 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.
Reimbursement for Adult Day Health Care (ADHC) 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 (HIPPA) compliant billing procedure code and modifier, when applicable. (Refer to Appendix C of this manual chapter for information about procedure codes, units of service and current reimbursement rate.)

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

**Support Coordination**

Support coordination services are provided as a separate service covered in the ADHC Waiver. Refer to Section 9.1 – Covered Services for detailed information regarding the reimbursement of this service.

**Transition Intensive Support Coordination**

Refer to Section 9.1 – Covered Services for detailed information regarding the reimbursement of this service.

**Transition Service**

Refer to Section 9.1 – Covered Services for detailed information regarding the reimbursement of this service.

**ADHC**

ADHC providers shall be reimbursed a per quarter hour rate for services provided under a prospective payment system (PPS) that recognizes and reflects the cost of direct care services provided.

Claims for ADHC service shall be filed by electronic claims submission 837P or on the CMS-1500 (02/12) claim form. Claims must be submitted after the week in which the service was delivered. Claims cannot be span-dated for a specified time-period. Each line on the claim form must represent billing for a single date of service. (Refer to Appendix E – Claims Filing for information about claims filing.)
ADHC Provider Cost Reporting

Providers of ADHC services are required to file acceptable annual cost reports of all reasonable and allowable costs. An acceptable cost report is one that is prepared in accordance with the requirements of this section of the ADHC Waiver Services manual chapter and for which the provider has supporting documentation necessary for completion of a desk review or audit. The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than five years following the date reports are submitted. A chart of accounts and an accounting system on accrual basis, or converted to the accrual basis at year end, are required in the cost report preparation process. The Bureau of Health Services Financing (BHSF) or its designee will perform desk reviews of the cost reports. A representative number of the facilities shall be subject to a full-scope, annual on-site audit. All ADHC cost reports shall be filed with a fiscal year from July 1 through June 30.

All ADHC centers must use the cost reporting forms and instructions developed by BHSF or its designee. Hospital-based and other provider based ADHCs which use Medicare forms for step down in completing their ADHC Medicaid cost reports must submit copies of the applicable Medicare cost report forms. All amounts must be rounded to the nearest dollar and must foot and cross foot. Only per diem cost amounts will not be rounded. Cost reports submitted that have not been rounded in accordance with this policy will be returned and will not be considered as received until they are resubmitted.

Cost reports are comprised of the following cost categories:

- Direct care costs;
- Care related costs;
- Administrative and operating costs;
- Property costs; and
- Transportation costs.

Direct Care Costs

Direct care costs include costs for in-house and contractual direct care staffing and fringe benefits and direct care supplies. Direct care costs include:

- Gross salaries of:
• Certified nurse aides;
• Nurse aides in training;
• Non-supervisory licensed practical nurses;
• Graduate practice nurses;
• Non-supervisory registered nurses;
• Graduate nurses (excluding director of nursing and resident assessment instrument coordinator);
• Non-supervisory licensed social services personnel providing medically needed social services to attain or maintain the highest practicable physical, mental or psychosocial well-being of the recipients; and
• Non-supervisory activities/recreational personnel providing ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental and psychosocial well-being of the recipients.

• Payroll taxes – the cost of the employer’s portion of:
  • Federal Insurance Contribution Act (FICA);
  • Federal Unemployment Tax Act (FUA);
  • State Unemployment Tax Act (SUA); and
  • Medicare tax for direct care employees.

• Group insurance – the cost of the employer’s contribution for direct care employees’.
  • Health insurance;
  • Life insurance;
  • Accident insurance; and
  • Disability insurance.

• Pensions – the cost of the employer’s contribution to employee pensions for direct care employees.

• Uniform allowance – the cost of uniform allowance and/or uniforms for the direct care employees.

• Worker’s compensation – the cost of worker’s compensation insurance for the direct care employees.

• Contract aides, licensed practical nurses, graduate practical nurses, registered nurses and graduate nurses hired through contract that are not center employees.
• Drugs – the cost of over-the-counter and legend drugs provided by the center to recipients not covered by Medicaid.

• Medical supplies – the cost of patient-specific items of medical supplies such as catheters, syringes, and sterile dressings.

• Medical waste disposal – the cost of medical waste disposal including storage containers and disposal costs.

• Other supplies – the cost of items used in the direct care of recipients which are not patient-specific such as recreational/activity supplies, prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers and blood pressure cuffs.

• Allocated costs, hospital based – the amount of costs that have been allocated through the step-down process from a hospital or state institution as direct care costs when those costs include allocated overhead.

• Total of all direct care costs – the sum of all of the line items of all of the previously listed direct care costs.

Care Related Costs

Care related costs include costs for in-house and contractual salaries and fringe benefits for activity and social services staff, raw food costs and care related supplies for activities and social services. Care related costs include:

• Salaries – the gross salaries for care related supervisory staff including supervisors or directors of nursing, social service and activities/recreation.

• Salaries – the gross salaries of kitchen personnel including dietary supervisors, cooks, helpers and dishwashers.

• Payroll Taxes – the cost of the employer’s portion of:
  • FICA;
  • FUTA;
  • SUTA; and
  • Medicare tax for care related employees.
• Group insurance – the cost of the employer’s contribution to employee health, life, accident and disability insurance for care related employees.

• Pensions – the cost of the employer’s contribution to employee pensions for care related employees.

• Uniform allowance – the employer’s cost of uniform allowance and/or uniforms for care related employees.

• Worker’s compensation – the cost of worker’s compensation insurance for care related employees.

• Contract, dietary – the cost of dietary services and personnel hired through contract that are not employees of the center.

• Barber and beauty expense – the cost of barber and beauty services provided to recipients for which no charges are made.

• Consultant fees – fees paid for advisory and educational services to the center by personnel not on the center’s payroll to the following:
  • Activities personnel;
  • Nursing personnel;
  • Registered pharmacist personnel;
  • Social worker personnel; and
  • Licensed therapist personnel.

• Food, raw – the cost of food products used to provide meals and snacks to recipients. Hospital based facilities must allocate food based on the number of meals served.

• Food, supplements – the cost of food products given in addition to normal meals and snacks under a doctor’s orders. Hospital-based facilities must allocate food supplements based on the number of meals served.

• Supplies – the cost of supplies used for rendering care related services to the recipients of the center. All personal care related items such as shampoo and soap administered by all staff must be included on this line.

• Allocated costs, hospital-based – the amount of costs that have been allocated through the step-down process from a hospital or state institution as care related
costs when those costs include allocated overhead.

- Total of all care related costs – the sum of the care related line item costs.

**Administrative and Operating Costs**

Administrative and operating costs include costs for in-house or contractual salaries and related benefits for administrative, dietary, housekeeping and maintenance staff. Also included are costs for utilities, accounting, dietary, supplies for housekeeping and maintenance and other administrative and operating type expenditures. Administrative and operating costs include:

- **Salaries** – gross salary of:
  - Administrators excluding owner. Hospital-based facilities must attach a schedule of the administrator’s salary before allocation, the allocation method, and the amount allocated to the nursing center;
  - Assistant administrators excluding owners;
  - Housekeeping personnel including housekeeping supervisors, maids and janitors;
  - Laundry personnel;
  - Personnel involved in operating and maintaining the physical plant, including maintenance personnel or plant engineers;
  - Other administrative personnel including bookkeepers, receptionists, administrative assistants and other office and clerical personnel; and
  - All owners of the center that are paid through the center.

- **Payroll taxes** – cost of employer’s portion of:
  - FICA;
  - FUTA;
  - SUTA; and
  - Medicare tax for administrative and operating employees.

- **Group Insurance** – cost of employer’s contribution to employee health, life, accident and disability insurance for administrative and operating employees.

- **Pensions** – cost of employer’s contribution to employee pensions for administration and operating employees.

- **Uniform allowance** – employer’s cost of uniform allowance and/or uniforms for administration and operating employees.
• Worker’s compensation – cost of worker’s compensation insurance for administration and operating employees.

• Contract – cost of services and personnel hired through contract that are not employees of the center for:
  • Housekeeping;
  • Laundry;
  • Maintenance; and
  • Registered dieticians.

• Accounting fees – fees incurred for:
  • Preparation of the cost report;
  • Audits of financial records;
  • Bookkeeping;
  • Tax return preparation of the ADHC center; and
  • Other related services excluding personal tax planning and personal tax return preparation.

• Amortization expense, non-capital – costs incurred for legal and other expenses when organizing a corporation must be amortized over a period of 60 months. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, are non-allowable when any payment has previously been paid, whether by acquisition or merger. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

• Bank service charges – fees paid to banks for service charges, excluding penalties and insufficient funds charges.

• Dietary supplies – costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc., used in the dietary department.

• Dues – dues to one organization are allowable.

• Educational seminars and training – the registration cost for attending educational seminars and training by employees of the center and costs incurred in the provision of in-house training for center staff, excluding owners or administrative personnel.
• Housekeeping supplies – cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

• Insurance, professional liability – includes the costs of insuring the center against injury and malpractice claims.

• Interest expense, non-capital and vehicles – interest paid on short-term borrowing for center operations.

• Laundry supplies – cost of consumable goods used in the laundry including soap, detergent, starch and bleach.

• Legal fees – only actual and reasonable attorney fees incurred for non-litigation legal services related to patient care are allowed.

• Linen supplies – cost of sheets, blankets, pillows, gowns, under-pads and diapers (reusable and disposable).

• Miscellaneous – costs incurred in providing center services that cannot be assigned to any other line item on the cost report. Items reported on this line must be specifically identified. Examples include:
  • Small equipment purchases;
  • All employees’ physicals and shots;
  • Nominal gifts to all employees such as a turkey or ham at Christmas;
  • Allowable advertising; and
  • Flowers purchased for the enjoyment of the recipients.

• Management fees and home office costs – cost of purchased management services or home office costs incurred that are allocable to the provider. Costs included that are for related management/home office costs must also be reported on a separate cost report that includes an allocation schedule.

• Office supplies and subscriptions – cost of consumable goods used in the business office such as:
  • Pencils, paper and computer supplies; and
  • Cost of printing forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, center letterhead and billing forms.
• Cost of subscribing to newspapers, magazines and periodicals.

• Postage – cost of postage, including stamps, metered postage, freight charges and courier services.

• Repairs and maintenance – supplies and services including electricians, plumbers, extended service agreements, etc., used to repair and maintain the center building, furniture and equipment except vehicles. This includes software maintenance.

• Taxes and licenses – the cost of taxes and licenses paid that are not included on any other line on Form 6. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

• Telephone and communications – cost of telephone services, fax services.

• Travel – cost of travel (airfare, lodging, meals, etc.) by the administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct center business. Community expenses and travel allowances are not allowable.

• Utilities – cost of water, sewer, gas, electricity, cable television and garbage collection services.

• Allocated costs, hospital-based – costs that have been allocated through the step-down process from a hospital as administrative and operating costs.

• Total all administrative and operating costs – the sum of the administrative and operating line item costs.

Property Costs

Property costs are for depreciation, interest on capital assets, lease expenses, property taxes and other expenses related to capital assets, excluding property cost related to patient transportation. Property costs include:

• Amortization expense, capital-legal and other costs incurred when financing the center must be amortized over the life of the mortgage. Amortization of goodwill is not an allowable cost. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made, are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.
• Depreciation on the center’s buildings, furniture, equipment, leasehold improvements and land improvements.

• Interest expense, capital – interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the center’s land, buildings and/or furniture, equipment and vehicles.

• Property insurance – cost of fire and casualty insurance on center buildings, equipment and vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

• Property taxes – taxes levied on the center’s buildings, equipment and vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

• Rent, building – cost of leasing the center’s real property.

• Rent, furniture and equipment – cost of leasing the center’s furniture and equipment, excluding vehicles.

• Allocated costs, hospital-based – costs that have been allocated through the step-down process from a hospital or state institution as property costs when those costs include allocated overhead.

• Total of all property and equipment costs – the sum of the property and equipment line item costs.

**Transportation Costs**

Transportation costs are for in-house and contractual driver salaries and related benefits, non-emergency medical transportation, vehicle maintenance and supply expense, and automotive expenses related to ADHC patient transportation. Transportation costs include:

• Gross salaries of personnel involved in transporting clients to and from the center.

• Non-emergency medical transportation – cost of purchased non-emergency medical transportation services including, but not limited to:
  • Payments to employees for use of personal vehicle;
  • Ambulance companies; and
• Other transportation companies for transporting recipients of the center.

• Vehicle expenses – cost of vehicle maintenance and supplies, including gas and oil.

• Automotive lease – cost of leases for vehicles used for patient care. A mileage log must be maintained. If a leased vehicle is used for both recipient care and personal purposes, cost must be allocated based on the mileage log.

• Total of all transportation costs – the sum of the transportation line item costs.

ADHC Provider Annual Reporting

Cost reports are to be filed on or before the last day of September following the close of the reporting period. Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date shall be the following business day. The cost report forms and schedules must be filed in duplicate together with two copies of the following documents:

• A working trial balance that includes the appropriate cost report line numbers to which each account can be traced. This may be done by writing the cost report category and line numbers by each ending balance or by running a trial balance in cost report category and line number order that totals the account.

• A depreciation schedule which reconciles to the depreciation expense reported on the cost report must be submitted. If the center files a home office cost report, copies of the home office depreciation schedules must also be submitted with the home office cost report. All hospital-based facilities must submit two copies of a depreciation schedule that clearly shows and totals assets that are hospital only, ADHC only and shared assets.

• An amortization schedule(s), if applicable.

• A schedule of adjustment and reclassification entries.

• A narrative description of purchased management services and a copy of contracts for managed services, if applicable.

• A description of the basis used to allocate the costs to providers in the group and to non-provider activities and copies of the cost allocation worksheet for management services provided by a related party or home office, if applicable. Costs included that are for related management/home office costs must also be reported on a separate cost report that includes an allocation schedule.
• All allocation worksheets by hospital-based facilities. Medicare worksheets that must be attached by facilities using the Medicare forms for allocation are:

  • A;
  • A-6;
  • A-7 parts I, II and III;
  • A-8;
  • A-8-1;
  • B part 1; and
  • B-1.

Each copy of the cost report must have the original signatures of an officer or center administrator on the certification. The cost report and related documents must be submitted to the address indicated on the cost report instruction form. In order to avoid a penalty for delinquency, cost reports must be postmarked on or before the due date.

The provider will be notified when it is determined, upon initial review for completeness, that an incomplete or improperly completed cost report has been submitted. The provider will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report.

For cost reports that are submitted by the due date, 10 working days from the date of the provider’s receipt of the request for additional information will be allowed for the submission of the additional information.

For cost reports that are submitted after the due date, five working days from the date of the provider’s receipt of the request for additional information will be allowed for the submission of the additional information. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. If requested additional information has not been submitted by the specified date, a second request for the information will be made. Requested information not received after the second request may not be subsequently submitted and shall not be considered for reimbursement purposes.

An appeal of the disallowance of the costs associated with the requested information may not be made. Allowable costs will be adjusted to disallow any expenses for which requested information is not submitted.
Accounting Basis

The cost report must be prepared on the accrual basis of accounting. If a center is on a cash basis, it will be necessary to convert from a cash basis to an accrual basis for cost reporting purposes. Particular attention must be given to an accurate accrual of all costs at the year-end for the equitable distribution of costs to the applicable period. Care must be given to the proper allocation of costs for contracts to the period covered by such contracts. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the reporting period.

Supporting Information

Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. Financial and statistical records must be maintained by the center for five years from the date the cost report is submitted. Cost information must be current, accurate and in sufficient detail to support amounts reported in the cost report. This includes all ledgers, journals, records, and original evidences of costs that pertain to the reported costs such as:

- Canceled checks;
- Purchase orders;
- Invoices;
- Vouchers;
- Inventories;
- Time cards;
- Payrolls; and
- Bases for apportioning costs.

Census data reported on the cost report must be supportable by daily census records. Such information must be adequate and available for auditing.

Allowable Costs

Allowable costs include those costs incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs. These general cost principles include determining whether the cost is:

- Ordinary, necessary and related to the delivery of care;
- What a prudent and cost conscious business person would pay for the specific
goods or services in the open market or in an arm’s length transaction; and

• For goods or services actually provided to the center.

Through the desk review and/or audit process, adjustments and/or disallowances may be made to a provider’s reported costs. The Medicare Provider Reimbursement manual is the final authority for allowable costs unless BHSF has a more restrictive policy.

Non-allowable Costs

Costs that are not based on the reasonable cost of services covered under Medicare and are not related to the care of recipients are considered non-allowable costs.

Reasonable cost does not include the following:

• Costs not related to recipient care;

• Costs specifically not reimbursed under the program;

• Costs that flow from the provision of luxury items or services (items or services substantially in excess or more expensive than those generally considered necessary for the provision of the care);

• Costs that are found to be substantially out of line with other centers that are similar in size, scope of services and other relevant factors; and

• Costs exceeding what a prudent and cost-conscious buyer would incur to purchase the goods or services.

General non-allowable costs include:

• Services for which Medicaid recipients are charged a fee;

• Depreciation of non-recipient care assets;

• Services that are reimbursable by other state or federally funded programs;

• Goods or services unrelated to recipient care; or

• Unreasonable costs.
Specific non-allowable costs (this is not an all-inclusive listing):

- Advertising – costs of advertising to the general public that seeks to increase patient utilization of the ADHC center;
- Bad debts – accounts receivable that are written off as not collectible;
- Contributions – amounts donated to charitable or other organizations;
- Courtesy allowances;
- Director’s fees;
- Educational costs for recipients;
- Gifts;
- Goodwill or interest (debt service) on goodwill;
- Costs of income producing items such as fund raising costs, promotional advertising, or public relations costs and other income producing items;
- Income taxes, state and federal taxes on net income levied or expected to be levied by the federal or state government;
- Insurance, officers – cost of insurance on officers and key employees of the center when the insurance is not provided to all employees;
- Judgments or settlements of any kind;
- Lobbying costs or political contributions, either directly or through a trade organization;
- Non-recipient entertainment;
- Non-Medicaid related care costs – costs allocated to portions of a center that are not licensed as the reporting ADHC or are not certified to participate in Medicaid;
- Officer’s life insurance with the center or owner as beneficiary;
- Payments to the parent organization or other related party;
• Penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, the Internal Revenue Service or the State Tax Commission, insufficient funds charges;

• Personal comfort items; and

• Personal use of vehicles.

**ADHC Provider Audits**

Each provider shall file an annual center cost report and, if applicable, a central office cost report, and shall be subject to financial and compliance audits.

All providers who elect to participate in the Medicaid program shall be subject to audit by state or federal regulators or their designees. Audit selection shall be at the discretion of BHSF.

• BHSF conducts desk reviews of all of the cost reports received and also conducts on-site audits of provider cost reports.

• The records necessary to verify information submitted to the BHSF on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to the audit staff.

In addition to the adjustments made during desk reviews and on-site audits, BHSF may exclude or adjust certain expenses in the cost report database in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

The center shall retain such records or files as required by BHSF and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

If a center’s audit results in repeat findings and adjustments, BHSF may:

• Withhold vendor payments until the center submits documentation that the non-compliance has been resolved;

• Exclude the provider’s cost from the database used for rate setting purposes; and

• Impose civil monetary penalties until the center submits documentation that confirms the non-compliance has been resolved.
If the auditors determine that a center’s financial and/or census records are un-auditable, the vendor payments may be withheld until the center submits auditable records. The provider shall be responsible for costs incurred by the auditors when additional services or procedures are performed to complete the audit.

Vendor payments may also be withheld under the following conditions:

- A center fails to submit corrective action plans in response to financial and compliance audit findings within 15 days after receiving the notification letter from the auditor; or

- A center fails to respond satisfactorily to the request for information within 15 days after receiving the notification letter.

The provider shall cooperate with the audit process by:

- Promptly providing all documents needed for review;

- Providing adequate space for uninterrupted review of records;

- Making persons responsible for center records and cost report preparation available during the audit;

- Arranging for all pertinent personnel to attend the closing conference;

- Insuring that complete information is maintained in recipient’s records; and

- Developing a plan of correction for areas of non-compliance with state and federal regulations immediately after the exit conference time limit of 30 days.
PROGRAM OVERSIGHT AND REVIEW

Services offered through the Adult Day Health Care (ADHC) waiver are closely monitored to assure compliance with Medicaid’s policy as well as applicable state and federal regulations. Oversight is conducted through licensure compliance and program monitoring. The Department of Health and Hospitals’ (DHH) Health Standards Section (HSS) staff conducts on-site reviews to assure state licensure compliance for the providers they license. The Office of Aging and Adult Services (OAAS) staff conducts review to monitor compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by individuals served.

On-site review of support coordination providers is conducted by the OAAS regional office staff. Details about the support coordination monitoring process are provided to support coordination providers at the time of enrollment.

Health Standards Section Reviews

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

- Recipient access to needed services identified in the Plan of Care and Individualized Service Plan,
- Quality of assessment and service planning,
- Appropriateness of services provided including content, intensity, frequency and recipient input and satisfaction, and
- Internal quality improvement.

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

On-Site Reviews

The HSS on-site review with a provider is unannounced to ensure licensure compliance. The on-site review is comprised of the following:

- Administrative Review,
- Personal Record Review,
• Interviews, and

• Recipient Record Reviews.

Administrative Review

The Administrative Review includes:

• A review of administrative records,

• A review of other agency documentation, and

• Provider agency staff interviews as well as interviews with recipients sampled 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 or liquidated damages and/or recoupment of payment.

Personnel Record Review

The Personnel Record Review includes:

• A review of personnel files,

• A review of time sheets,

• A review of the current organizational chart, and

• Provider agency staff interviews to ensure that service providers, and all supervisors meet the following staff qualifications:

  • Education,
  • Experience,
  • Skills,
  • Knowledge,
  • Employment status,
  • Hours worked,
  • Staff coverage,
  • Supervisor-support coordinator ratio,
  • Caseload/recipient assignments,
• Supervision documentation, and
• Other applicable requirements.

**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 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, direct service providers and other employees of the service provider agency.

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

**Recipient Record Review**

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

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

• Identified in the Plan of Care and Individualized Service Plan (if applicable),

• Provided to the recipient,

• Documented properly, and

• Are appropriate in terms of frequency and intensity.
The HSS staff will review the intake documentation of the ADHC Waiver recipient’s eligibility and procedural safeguards, support coordination and professional assessments/reassessment documentation, service plans, service logs, progress notes and other pertinent information in the recipient record.

**Report of Review Findings**

Upon completion of the on-site review, the HSS staff discusses the preliminary findings of the review in an exit interview with appropriate staff of the support coordination or ADHC provider agency. 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,
- A statement of compliance with all applicable regulations, or
- Deficiencies requiring corrective action by the support coordination or ADHC provider agency.

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 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 of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits their rights to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix A 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 time and place where the informal hearing will be held. 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 will conduct the hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the monitoring findings. The provider representatives are advised of the date that a written response will be sent and are reminded of its right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Division of Administrative Law.

Fraud and Abuse

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

Support Coordination Monitoring

The OAAS regional staff conducts annual monitoring of each support coordination provider as a means of monitoring compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by individuals served. The results of the monitoring process are reported to the support coordination provider along with any required
follow-up actions and timelines. Recurrent problems are to be addressed by the support coordination provider through systemic changes resulting in improvements. Support coordination providers who do not perform all of the required follow-up actions according to the specified timelines, are subject to sanctions.

Support coordination providers are responsible for the following in the monitoring process:

- Offering full cooperation with the OAAS,
- Providing policy and procedure manuals, personnel records, case records, and other documentation, as requested,
- Providing space for documentation review and support coordinator interviews,
- Coordinating with agency support coordinator interviews, and
- Assisting with scheduling recipient interviews.
INCIDENTS, ACCIDENTS AND COMPLAINTS

Adult Day Health Care (ADHC) and support coordination providers are responsible for reasonably ensuring the health and welfare of the recipient and are required to report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion. Reporting shall be in accordance with applicable laws, rules and policies and be made to the appropriate agency named below. Only reporting to a supervisor does not satisfy the legal requirement to report. The supervisor shall be responsible for ensuring that reports or referrals are made in a timely manner to the appropriate agency.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of all incidents and accidents involving the recipient. A report of the incident/accident shall be maintained in the recipient’s record. The report shall include:

- Date of the incident/accident,
- Circumstances surrounding the incident/accident,
- Description of medical attention required,
- Action taken to correct or prevent incident/accident from occurring again, and
- Name of person completing the report.

Critical Incident Reports

Additional provider responsibilities apply to incidents defined as critical. Critical incidents include, but are not limited to those involving abuse, neglect, exploitation, extortion, major injury, involvement with law enforcement, major illness, elopement/missing, falls and major medication incidents of the recipient. Critical incidents are fully defined in Office of Aging and Adult Services’ (OAAS) Critical Incident Policy and Procedures and include the specific provider responsibilities that must be followed. Non-compliance will result in administrative actions. (See Appendix B for information on obtaining this policy)

Imminent Danger and Serious Harm

Providers shall report all suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion to the appropriate authorities. In addition, any other circumstances that place the recipient’s health and well-being at risk should be reported to Protective Services.
Protective Services is responsible for investigating reports and arranging for services to protect vulnerable adults/elders who are at risk of abuse, neglect, exploitation or extortion who live in unlicensed and non-regulated facilities. (See Appendix A for contact information)

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

The responsibilities of the support coordination provider and the direct service provider are outlined in the OAAS Critical Incident Reporting Policy and Procedures. (See Appendix B for information on obtaining this policy)

**Internal Complaint Policy**

Recipients must be able to file a complaint regarding their services without fear of reprisal. The provider shall have a written policy to handle recipient 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.

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

- 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, the responsible representative, the employee, and other interested parties. The provider is encouraged to use all available resources to resolve the complaint internally. The employee’s supervisor must be informed of the complaint and the resolution.

- The provider must inform the recipient, the complainant, and/or the responsible representative in writing within ten working days of receipt of the complaint and the results of the internal investigation.
• If the recipient is dissatisfied with the results of the internal investigation, he/she may continue the complaint resolution process by contacting the Health Standards Section. (See Appendix A for contact information)

• If the recipient is dissatisfied with the results of the support coordination agency’s internal investigation, he/she may continue the complaint resolution process by contacting the Office of Aging and Adult Services regional office. (See Appendix A for contact information)
SUPPORT COORDINATION

Support coordination, also referred to as case management, 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 Adult Day Health Care 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

The applicant must be contacted to obtain the required demographic information within three working days of receipt of the Freedom of Choice (FOC) form from the data management contractor.

If medical information is required, the support coordinator must obtain signed medical release forms from the applicant/family.

Support coordinators must also ensure applicants/families are:

- Informed of procedural safeguards,
• Informed of their rights along with grievance procedures,

• Advised of their responsibilities,

• Advised of the right to change support coordination providers, support coordinators, service providers, and

• Advised that waiver services and support coordination service are an alternative to institutionalization.

Assessment

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

Assessment Process

The person-centered assessment consists of the following:

• Face-to-face interviews with the recipient/recipient’s family or guardian in the recipient’s home,

• 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

• Information about the freedom of choice of all services and waiver services as an alternative to institutionalization.

Characteristics and components of the assessment include:

• Identifying information (demographics),

• The use of a standardized instrument for certain targeted populations (Minimum Data Set-Home Care (MDS-HC),
• Personal outcomes identified, defined and prioritized by the recipient,
• Medical/physical information,
• Psycho social/behavioral information,
• 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, and
• 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).

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 any information/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/responsible representative to secure appropriate services.

A signed authorization for release of information must be obtained and filed in the case record. If the services in the Adult Day Health Care 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 will be notified in writing, given appeal rights and directed to other service options, as applicable.
Time Frame for Initial Assessment

The initial assessment must occur within seven business days from the date of the referral/linkage.

Ongoing Assessment Procedures

When there are changes in the recipient’s life or in prioritized personal outcomes, the support coordinator must complete another assessment. This includes changes in status, strengths, preferences, abilities and the resources of the recipient. If there are significant changes in the recipient’s status, the support coordinator must revise the Plan of Care.

Plan of Care Development and Implementation

The Plan of Care is the analysis of gathered information from the recipient/responsible representative and the person-centered assessment process, and is based on the unique personal outcomes identified, defined and prioritized by the recipient.

The Plan of Care is developed through a collaborative process involving the recipient, family, friends or other support systems, the support coordinator, transition coordinator (if applicable) and appropriate professionals/service providers and others who know the recipient best.

The Plan of Care serves to:

- Establish direction for all persons involved in providing supports and services for the recipient by describing how the necessary 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 Plan of Care should not be considered a treatment plan of specific clinical interventions that service providers would use to achieve treatment or rehabilitation goals. Instead, the Plan of Care 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.
Required Procedures

The Plan of Care must be completed in a face-to-face visit with the recipient, and members of his/her support network, which may include family members, appropriate professionals, and others, who are well acquainted with the recipient. The Plan of Care meeting must be held at a time that is convenient for the recipient.

The support coordinator must first identify on the Plan of Care the supports and services (e.g. natural supports, home health services, hospice, etc.) that are currently being provided to the recipient and then identify and develop a plan to obtain those needed supports/services the recipient is not receiving.

The Plan of Care must be outcome-oriented, individualized and time limited. The planning process should include tailoring the Plan of Care 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 (e.g. home health services, hospice, etc.). The recipient, support coordinator, members of the recipient’s support system, including appropriate professional personnel, must be directly involved in the development of the Plan of Care.

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

The Plan of Care 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 Plan of Care must incorporate the following required components and shall be prepared by the support coordinator with the recipient, personal representative/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,
- 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 Plan of Care and recipient’s desired outcomes,
- Change in a waiver service provider(s) can only be requested by the recipient prior to the end of a quarter or at an annual visit, unless there is “good cause.” Any request for a change requires a completion of a Freedom of Choice form. A change in direct service providers is to be made through the support coordinator,
- Change in a support coordination provider can only be requested every six months or at any time with “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 Office of Aging and Adults Services (OAAS) regional office.
- All participants present at the Plan of Care meeting must sign the Plan of Care,
- The Plan of Care must be completed and approved as per Plan of Care instructions,
- The recipient must be informed of his/her right to refuse a Plan of Care after carefully reviewing it.
Building and Implementing Supports

The implementation of the Plan of Care 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 Plan of Care,
- 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 Plan of Care,
- 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 Plan of Care,
• 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 quarterly and for each annual Plan of Care 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

For recipients who reside in the community, the Plan of Care must be completed and approved by the OAAS designee or OAAS regional office within **35 calendar days** following the date of the notification of linkage by the data management contractor. All incomplete packages will be returned.

For recipients who reside in a nursing facility, the Plan of Care must be completed and approved by the OAAS designee or OAAS regional office, within **45 calendar days** following the date of the notification of linkage by the data management contractor. All incomplete packages will be returned.

• Routine Changes

Routine changes, such as changes in service (e.g., increase or decrease in service hours), must be submitted within five calendar days from the date of the reported change.

• Emergency Changes

Emergency changes must be submitted within 24 hours from the date of the reported change.

• Reviews

The Plan of Care must be reviewed monthly to ensure that the personal outcomes and support strategies are consistent with the recipient’s preferences.

The Plan of Care must be revised and approved annually (and as required) by the OAAS designee or OAAS regional office no later than 14 days prior to Plan of Care expiration date.
Changes in the Plan of Care

If there are significant changes in the support strategies or service providers, the support coordinator must complete another assessment and revise the Plan of Care to reflect these changes. A revision request must be submitted for approval/disapproval to the OAAS designee or OAAS regional office, if applicable.

There is flexibility in the Plan of Care 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 Plan of Care.

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 (if applicable) to complete the Plan of Care revision form. All participants will sign the revised Plan of Care (if applicable) and it will be submitted to the OAAS designee or OAAS regional office, as applicable, for approval/disapproval.

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

For recipients that are certified for waiver services but still residing in a nursing facility after one year, the support coordinator must complete a revision to the Plan of Care that extends the Plan of Care end date for 3 months allowing the recipient additional time to move into the community. The recipient’s signature is not required.

Documentation

A copy of the approved Plan of Care must be kept in the recipient’s home, in the recipient’s case record in the support coordination provider and service providers’ files. The support coordinator is responsible for providing copies of the Plan of Care to the recipient and the direct service provider.

Support Coordination Follow-Up/Monitoring

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

Every calendar month after Plan of Care approval, the support coordinator must make telephone 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,

• 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 the recipient’s status or if problems arise with service providers. A change in the recipient’s status may require a reassessment.

Support coordinators must notify service providers within three working days of Plan of Care approval.

Support coordinators must meet face-to-face with the recipient quarterly to determine the effectiveness of the support strategies, and, if necessary, to revise the Plan of Care.

All visits and contacts should be documented in accordance with OAAS documentation and data-entry requirements. (Refer to Section 9.6 of this manual chapter)

**Reassessment**

Assessment must be ongoing to reflect changes in the recipient’s life and changing prioritized personal outcomes over time such as strengths, preferences, abilities and the recipient’s resources. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall Plan of Care.

A reassessment may be required when a recipient experiences a change in status, or there is a change in the recipient’s family, or the recipient’s prioritized needs.
Follow-up Reassessments - Nursing Facility Transitions

A follow-up reassessment must be completed by the support coordinator six months from the date the recipient moved out of the nursing facility. If the six month date falls on a weekend or holiday, the reassessment must be completed on the following working day.

Change in Status Reassessment

A change in status reassessment must be completed by the support coordinator when there is a significant status change in the recipient’s condition. This reassessment must be completed by the fourteenth calendar day from the date of the notice of the change in the recipient’s condition.

Annual Reassessment

An annual reassessment must be completed by the support coordinator no earlier than 90 calendar days prior to the Plan of Care expiration date.

Transition/Closure

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.

NOTE: Support coordinators cannot close waiver cases until approval is received from OAAS, unless the reason for closure is “death”.

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 (longer than 90 consecutive days) to an acute care hospital, rehabilitation hospital, institution or nursing facility
- The recipient requires a level of care beyond that which can safely be provided through waiver services,
• Continuity of services is interrupted as a result of the recipient not receiving or refusing ADHC waiver services (exclusive of support coordination services) for a period of 30 consecutive days,

• Recipient refuses to comply with program requirements, or

• It is not cost effective to serve the recipient in the ADHC waiver.

Procedures for Transition/Closure

The support coordinator must provide assistance to the recipient and to the receiving provider during a transition to assure a smooth transition process. 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 provider, program or support coordinator receives copies of the most current Plan of Care and related documents. (The form 148-W must be completed to reflect the date on the transfer of records and submitted to the OAAS regional office),

• 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.

Note: A support coordination provider 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 an appeal is not requested with ten days of adverse action notice, the case will be closed.

The provider shall not retaliate in any way against the recipient for terminating services or for transferring to another provider for support coordination services.
Changing Support Coordination Agencies

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

Upon receipt of the completed form, the transferring support coordination provider must provide copies of the following information to the receiving support coordination provider:

- Most current Plan of Care,
- Current assessment on which the Plan of Care is based,
- Number of services used in the calendar year, and
- Most recent six months of progress notes.

The transferring support coordination provider shall provide services up to the transfer of the records and is eligible to bill for support coordination services during the month of transfer when the provider has cooperated and met all requirements. In the month the transfer occurs, the receiving support coordination provider 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.

Other Support Coordination Responsibilities

The support coordinator is responsible for coordination of the recipient’s Community Choices Waiver services in a way that does not duplicate services when the recipient is also receiving other services such as home health, or hospice services.

Incidents, Accidents and Complaints

The support coordination provider must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OAAS and appropriate agency as mandated by law and OAAS policies and procedures. (Refer to Section 9.9 of this manual chapter for additional information)
## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>OFFICE NAME</th>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
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</table>
| OAAS State Office                 | Provides waiver assistance, clarification of waiver services, receives complaints regarding waiver services | Office of Aging and Adult Services
  P. O. Box 2031
  Baton Rouge, LA 70821-2031
  1-866-758-5035                  |
| OAAS Regional Offices             | Reviews and provides approval of waiver services, monitors support coordination services and offers providers technical assistance | http://new.dhh.louisiana.gov/index.cfm/directory/category/141 |
| Division of Administrative Law-Health and Hospitals Section | Office to contact to request an appeal hearing | 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 |
| Health Standards Section          | Office to contact when providers wish to request an informal hearing as the result of a monitoring corrective action report or file a complaint against a provider agency | Health Standards Section
  Attn: IDR Program Manager
  P.O. Box 3767
  Baton Rouge, LA 70821
  1-800-660-0488 |
| Protective Services               | Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults living in the community | 1-800-898-4910                   |
| Myers and Stauffer LC             | Information about filing cost reports                                              | http://la.mslc.com/downloads.aspx |
The following forms and procedural policies are available on the Office of Aging and Adult Services’ (OAAS) website:

<table>
<thead>
<tr>
<th>Form/Document Name</th>
<th>Web Address</th>
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</thead>
<tbody>
<tr>
<td>OAAS Transition Services Form (TSF)</td>
<td><a href="http://new.dhh.louisiana.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf">http://new.dhh.louisiana.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf</a></td>
</tr>
<tr>
<td>Request for Payment/Override Form</td>
<td><a href="http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/Request-for-Payment-Override-Form.pdf">http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/Request-for-Payment-Override-Form.pdf</a></td>
</tr>
</tbody>
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BILLING CODES

Information on procedure codes and the current rates is available at:

GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Adult Day Health Care (ADHC) Waiver Manual Chapter.

**Abuse** – The infliction of physical or mental injury on a recipient 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/her health, self-determination, or emotional well-being is endangered. (La. R.S. 15.1503)

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

**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 of these activities often is a level of care criterion.

**Adult Day Health Care (ADHC)** – a medical program model designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community based nursing center.

**Adult Day Health Care Center** – any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more adults with functional impairments who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days a week.

**Adult Day Health Care (ADHC) Waiver** – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to adults age 65 or older with functional impairments, or adults between ages 22 and 65 who have a disability according to Medicaid standards.

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

**Allegation of non-compliance** – A claim 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)

Allowable Cost – Those expenses incurred by the provider agency which are reasonable in amount and are necessary for the efficient delivery of support coordination services.

Appeal – A due process system of procedures which ensures a recipient will be notified of and have an opportunity to contest a Department of Health and Hospitals (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 and an Individualized Service Plan.

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

Case Management – Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational, housing, 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. Case management is also referred to as support coordination.

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

Community Choices Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to adults age 65 or older, or between the ages of 21 and 65 with functional impairments, and are disabled according to Medicaid standards.

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

Continuous Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to
pursue opportunities to improve services, and to correct identified problems.

**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).

**Corrective Action Plan** – Written description of action a provider agency plans to take to correct identified deficiencies.

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

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

**Direct Care Staff** – Unlicensed staff paid to provide personal care or other direct service and support to persons with disabilities or to the elderly to enhance their well-being. This is also referred to as a Direct Service Worker.

**Disabled Person** – A person with a mental, physical, or developmental disability that substantially impairs the person’s ability to provide adequately for his own care or protection.

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

**Enrollment** – A determination made by DHH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other DHH-funded services. This is also referred to as provider enrollment or certification.

**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 an aged person’s or disabled adult’s power of attorney or guardianship for one’s own profit or advantage. (La. R.S. 15:1503)

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

**Fiscal Intermediary** – The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.
Follow-Up – A core element of service delivery that includes oversight and monitoring of the provision of services to the recipient.

Formal Services – Another term for professional and paid services.

Good Cause – When the OAAS regional office approves a recipient’s change in support coordination or provider agencies outside the timelines noted in policy if one of the following exists: the recipient is moving to another region in the state where the current provider does not provide services; the recipient and provider have unresolved difficulties and mutually agree to a transfer; the recipient’s health or welfare has been compromised; or the provider has not rendered services in a manner satisfactory to the recipient.

Health Standards Section – A section of the Department of Health and Hospitals responsible for the licensure and oversight of certain individual and agency providers of services funded by the DHH.

Home and Community-Based Services Waiver – 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. The number of individuals receiving these services is limited to the number of approved and available waiver opportunities.

Individualized Service Plan – 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 the recipient’s approved Plan of Care.

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

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

Licensed Practical Nurse (LPN) – an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse.

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.

**Medicaid** – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

**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. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

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

**Minimal Harm** – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the consumer’s activities of daily living. (La. R.S. 40:2009.14)

**Neglect** – The failure by a care giver responsible for an adult’s care or by other parties 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. (La. R.S. 15:1503)

**Nursing Facility (NF)** – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.

**Office of Aging and Adult Services (OAAS)** – The office within the Department of Health and Hospitals that is responsible for the management and oversight of certain Medicaid home and community-based state plan and waiver programs and protective services for adults ages 18 through 59.

**OAAS Regional Office** – One of nine administrative offices within the Office of Aging and Adult Services.
Office of Behavioral Health (OBH) – The office in DHH that is responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (OPH) – The office in DHH responsible for personal and environmental health services.

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

Person-Centered Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized POC.

Plan of Care (POC) – A written plan developed by the recipient, his/her responsible representative and support coordinator that is based on assessment results and specifies services to be accessed and coordinated by the support coordinator on the recipient’s behalf. It includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Primary Care Physician – A physician, currently licensed by the Louisiana State Board of Medical Examiners, who is designated by the recipient or his/her personal representative as responsible for the direction of the recipient’s overall medical care.

Progress Notes – Ongoing assessment of the recipient which enables the staff to update the Plan of Care and/or Individualized Service Plan in a timely, effective manner.

Provider/Provider Agency – An agency furnishing Medicaid services under a provider agreement with DHH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other DHH funding source. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other DHH funding source.

Provider Enrollment – Another term for enrollment.

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 revising the overall Plan of Care and/or Individualized Service Plan.

Recipient – An individual who has been certified for medical benefits by the Medicaid program. A recipient certified for Medicaid home and community-based waiver services may also be referred to as a participant.
Registered Nurse (RN) – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

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.

Responsible Representative – An adult who has been designated by the recipient to act on his/her behalf with respect to his/her services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient’s business without the recipient’s involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction. This is also referred to as a designated personal representative.

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 healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 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.

Support Coordination – See case management.

Support Coordinator – An individual who meets the required qualifications and who is employed by a public or private entity to provide case management (support coordination) services.

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.

Trivial Report – A report 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)

**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. See also Home and Community-Based Services Waiver.

**Waiver Opportunity** – An opportunity for an eligible application who meets the requirements for institutional care to receive XIX waiver services. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.
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

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid website at [www.lamedicaid.com](http://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 samples of completed CMS-1500 claim forms; and

- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.
CMS 1500 (02/12) INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC) SERVICES EFFECTIVE WITH DATE OF SERVICE 4/1/16

You must write “WAIVER” at the top center of the claim form!

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung</td>
<td>Required -- Enter an “X” in the box marked Medicaid (Medicaid #).</td>
<td>You must write “WAIVER” at the top center of the Louisiana Medicaid claim form.</td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s I.D. Number</td>
<td>Required – Enter the recipient’s 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.</td>
<td>Formerly UB-04 Locator 60.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NOTE:</strong> 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.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td>Required – Enter the recipient’s last name, first name, middle initial.</td>
<td>Formerly UB-04 Locator 8 &amp; 58.</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td>Situational – Enter the recipient’s date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).</td>
<td>Formerly UB-04 Locator 10 &amp; 11.</td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td>Enter an “X” in the appropriate box to show the sex of the recipient.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td>Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td>Optional – Print the recipient’s permanent address.</td>
<td>Formerly UB-04 Locator 9.</td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
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<td>---------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured's Name</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td>Formerly UB-04 Locator 61. ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured's Policy or Group Number</td>
<td>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 \textbf{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.</td>
<td></td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is Patient's Condition Related To:</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured's Policy Group or FECA Number</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Insured's Date of Birth</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient's or Authorized Person's Signature (Release of Records)</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Insured's or Authorized Person's Signature (Payment)</td>
<td>Situational – Obtain signature if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness / Injury / Pregnancy</td>
<td>Leave Blank.</td>
<td></td>
</tr>
</tbody>
</table>
## Chapter 9: Adult Day Health Care Waiver

### Appendix E – Claims Filing

<table>
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<tr>
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<th>Instructions</th>
<th>Alerts</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Other Date</td>
<td>Leave Blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td>Leave Blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
<td>Leave Blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>Unlabeled</td>
<td>Leave Blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td>Leave Blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>Leave Blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Additional Claim Information (Designated by NUCC)</td>
<td>Leave Blank,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab?</td>
<td>Leave Blank.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ICD Indicator

**Required** – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.

- **0** ICD-10-CM

#### Diagnosis or Nature of Illness or Injury

**Required** – Enter the ICD 10 diagnosis code Z76.89.

**NOTE:** The ICD-10-CM "V", "W", "X", and "Y" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.

**Formerly UB-04 Locator 66.**

**Formerly UB-04 Locator 67.**

**Diagnosis Code Z76.89 may be used on all ADHC claims.**
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Resubmission Code</td>
<td><strong>Situational.</strong> If filing an adjustment or void, enter an &quot;A&quot; for an adjustment or a &quot;V&quot; for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the “Original Ref. No.” portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</td>
<td>Formerly UB-04 Locator 64. 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.</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization (PA) Number</td>
<td><strong>Required</strong> – Enter the 9-Digit PA number in this field.</td>
<td>Formerly UB-04 Locator 63.</td>
</tr>
<tr>
<td>24</td>
<td>Supplemental Information</td>
<td><strong>Situational -</strong> Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>24A</td>
<td>Date(s) of Service</td>
<td><strong>Required</strong> -- Enter the date of service for each procedure.  Bill one date of service per claim line. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable. A separate claim must be billed for each month if the recipient’s dates of service cross the end of a calendar month.</td>
<td>Formerly UB-04 Locator 45. Note: Claims must be split billed at the end of each month.</td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td><strong>Required</strong> – Enter the appropriate place of service code for the services rendered.</td>
<td></td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
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</tr>
<tr>
<td>24D</td>
<td>Procedures, Services, or Supplies</td>
<td>Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S5100 – ADHC Services</td>
<td>Formerly UB-04 Locator 44.</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block.</td>
<td></td>
</tr>
<tr>
<td>24F</td>
<td>Amount Charged ($ Charge)</td>
<td>Required -- Enter usual and customary charges for the service rendered.</td>
<td>Formerly UB-04 Locator 47.</td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
<td>Required -- Enter the number of units billed for the procedure code entered on the same line in 24D</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NOTE: ADHC cannot exceed 10 hours (40 units) each day and 50 hours (200 units) per week.</td>
<td>Formerly UB-04 Locator 46.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reminder: 1 Unit is equal to 15 minutes of service</td>
<td></td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT Family Plan</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider I.D. #</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account No.</td>
<td>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.</td>
<td>Formerly UB-04 Locator 3A.</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Required -- Enter the total of all charges listed on the claim.</td>
<td>Formerly UB-04 Locator 47.</td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>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.</td>
<td>Formerly UB-04 Locator 54.</td>
</tr>
<tr>
<td>30</td>
<td>Reserved for NUCC use</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials Date</td>
<td>Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of the signature.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td>Situational – Complete as appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>32b</td>
<td>Unlabeled</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Phone #</td>
<td>Required -- Enter the provider name, address including zip code and telephone number.</td>
<td>Formerly UB-04 Locator 1.</td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td>Required – Enter the billing provider's 10-digit NPI number.</td>
<td>Formerly UB-04 Locator 56. The 10-digit NPI must appear on paper claims.</td>
</tr>
<tr>
<td>33b</td>
<td>Unlabeled</td>
<td>Required – Enter the billing provider's 7-digit Medicaid ID number.</td>
<td>Formerly UB-04 Locator 57. The 7-digit Medicaid Provider Number must appear on paper claims.</td>
</tr>
</tbody>
</table>

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

Sample forms are on the following pages
**Sample ADHC Claim Form with ICD-10 Diagnosis Code (Dates on or after 10/01/15)**

### HEALTH INSURANCE CLAIM FORM

**WAIVER**

**Sample ADHC Claim Form**

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Diagnosis Code</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Allowable Charge</th>
<th>Actual Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/16</td>
<td>Z76.80</td>
<td>95100</td>
<td>1</td>
<td>72.00</td>
<td>24</td>
</tr>
<tr>
<td>04/04/16</td>
<td>Z76.80</td>
<td>95100</td>
<td>1</td>
<td>96.00</td>
<td>32</td>
</tr>
<tr>
<td>04/06/16</td>
<td>Z76.80</td>
<td>95100</td>
<td>1</td>
<td>120.00</td>
<td>40</td>
</tr>
</tbody>
</table>

**Additional Information:**

- Medicare Number: [Redacted]
- Other Insurers: [Redacted]
- Provider Number: [Redacted]

**Claimant Information:**

- Name: [Redacted]
- Address: 9876 Lollipop Lane, ANYWHERE, LA 7111
- Phone: 555-4567

**Provider Information:**

- Name: JOHN DOE
- Address: [Redacted]
- Phone: 225-655-4567

**Signature:** [Redacted]

**Diagnosis:** Z76.80

**Procedure:** 95100

**Notes:**

- Please print or type.
- Approved CMS-1500 form 05/01/12.
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 internal 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.
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.

Sample forms are on the following pages.
SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE 
(DATES ON OR AFTER 10/01/15)

Example of Adjustement Claim
SAMPLE CLAIM FORM

HEALTH INSURANCE CLAIM FORM

1. MEDICARE
   2. MEDICAID
   3. TRICARE
   4. CHAMPVA
   5. OTHER MEDICAID PROGRAM

1a. PATIENT'S ID NUMBER
   1b. PATIENT'S NAME
       (Last Name, First Name, Middle Initial)

2. PATIENT'S ADDRESS
   CITY
   STATE
   ZIP CODE
   TELEPHONE

3. PATIENT'S BIRTH DATE
   DAY
   MONTH
   YEAR

4. OTHER INSURED'S NAME
   LAST NAME
   FIRST NAME
   MIDDLE INITIAL

5. OTHER INSURED'S ROS
   RELATIONSHIP TO PATIENT
   SPOUSE
   CHILD
   OTHER

6. PATIENT'S INSURED ADDRESS
   CITY
   STATE
   ZIP CODE
   TELEPHONE

7. PATIENT'S RELATIONSHIP TO INSURED
   SPOUSE
   CHILD
   OTHER

8. PATIENT'S SOCIAL SECURITY NUMBER

9. PATIENT'S DATE OF BIRTH
   DAY
   MONTH
   YEAR

10. PATIENT'S OCCUPATION
    EMPLOYER
    EMPLOYMENT

11. PATIENT'S HEALTH INSURANCE
    PROVIDER'S NAME
    ADDRESS

12. PATIENT'S MEDICAL HISTORY
    ALLERGIES
    MEDICATION

13. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    PREVIOUS SURGERY

14. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    ICD-10 CODE

15. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

16. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    MEDICATION

17. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

18. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

19. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

20. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

21. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

22. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

23. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

24. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

25. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

26. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

27. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

28. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

29. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

30. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

31. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

32. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

33. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

34. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

35. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

36. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

37. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

38. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

39. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

40. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

41. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

42. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

43. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

44. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

45. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

46. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

47. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

48. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

49. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

50. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

51. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

52. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

53. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

54. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

55. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

56. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

57. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

58. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

59. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

60. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

61. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

62. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

63. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

64. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

65. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

66. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

67. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

68. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

69. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

70. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

71. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

72. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE

73. PATIENT'S MEDICAL HISTORY
    PREVIOUS HOSPITALIZATION
    HOSPITALIZATION DATE

74. PATIENT'S MEDICAL HISTORY
    PREVIOUS MEDICATION
    MEDICATION DATE

75. PATIENT'S MEDICAL HISTORY
    PREVIOUS DIAGNOSIS
    DIAGNOSIS CODE

76. PATIENT'S MEDICAL HISTORY
    PREVIOUS TREATMENT
    TREATMENT DATE

77. PATIENT'S MEDICAL HISTORY
    PREVIOUS SURGERY
    SURGERY DATE