



NEW OPPORTUNITIES WAIVER (NOW)

Chapter Thirty-Two of the Medicaid Services Manual

Issued March 1, 2011

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

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

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OVERVIEW

The New Opportunities Waiver (NOW) program is a Medicaid waiver designed to provide home and community-based services (HCBS) and supports to beneficiaries with developmental disabilities who require the level of care (LOC) of an intermediate care facility for individuals with intellectual disabilities (ICF/IID). This waiver is operated by the Office for Citizens with Developmental Disabilities (OCDD) under the authorization of the Bureau of Health Services Financing (BHSF). Both OCDD and BHSF are agencies within the Louisiana Department of Health (LDH).

The objectives of the NOW program are to offer an alternative to institutionalization and promote independence and community inclusion for beneficiaries through the provision of services. The NOW program utilizes the principles of self-determination as a foundation for supports and services and to supplement the family and/or community supports that are available to maintain the beneficiary in the community.

The NOW program includes an array of services such as residential supports, respite, community integration and development, employment-related supports, habilitation, environmental modifications and specialized equipment, professional services, as well as other services. The NOW program also includes a self-direction option which allows beneficiaries or their authorized representative to act as the employer in the delivery of their designated self-directed services. This option provides beneficiaries with maximum flexibility and control over their supports and services. NOW services should not be viewed as a lifetime entitlement or a fixed annual allocation. The average beneficiary's expenditures for all waiver services must not exceed the average Medicaid expenditures for ICF/IID services.

Providers are responsible for complying with the requirements in Chapter 1, "General Information and Administration Provider Manual" of the *Medicaid Services Manual*. This manual is available on the Louisiana Medicaid website under the "Provider Manuals" tab or at: www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf.

Services provided in NOW are community-based, and designed to allow an individual experience that mirrors experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering beneficiaries to experience life in the most fulfilling manner as defined by the beneficiary while still assuring health and safety.

Beneficiaries have the choice of available support coordination and service provider agencies and are able to select enrolled qualified agencies through the freedom of choice process. Beneficiaries also have the right to request changes to the staff that support them. NOW services are accessed through the beneficiary's support coordinator and are based on the individual needs and preferences of the beneficiary. A support team, which consists of the beneficiary, support coordinator, beneficiary's authorized representative, appropriate professionals/service providers, and others whom the beneficiary chooses, is established to develop the beneficiary's plan of care

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(POC) through a person-centered planning process. The POC contains all services and activities involving the beneficiary, including non-waiver services as well as waiver support services. The completed POC is submitted to the support coordination agency (SCA) supervisor or local governing entity (LGE) for review and approval as designated in OCDD policy. All POCs approved by the SCA supervisor shall be submitted to the LGE.

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

Services provided in the NOW program must comply with the Centers for Medicare and Medicaid Services (CMS) HCBS Settings Final Rule 42 Code of Federal Regulations (CFR) 441.530. Services provided in the NOW program must meet the following criteria:

1. Beneficiaries receiving any NOW services are expected to be integrated in and have full access to the greater community while receiving services, as well as have opportunities to seek employment and work in competitive integrated settings. Additionally, Beneficiaries have the right to control their personal resources, engage in community life, and receive services in the community to the same degree of access as individuals not receiving HCBS;
2. The setting is selected by the beneficiary from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;
3. The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint, including the right to respectful interactions and privacy in both residential and non-residential settings;
4. The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact;
5. Beneficiaries have choice regarding services and supports, and who provides them;
6. Beneficiaries can control their own schedule and activities, including access to food at any time to the same extent as individuals who are not receiving Medicaid HCBS;

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7. Beneficiaries are able to have visitors of their choosing at any time to the same extent as individuals who are not receiving Medicaid HCBS;
8. The setting where services are provided must be physically accessible to the individual such that all areas of normal access are not restricted; and
9. Residential settings owned or controlled by the provider must also meet the following requirements:
 - a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS beneficiary, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
 - b. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. Individuals in provider owned or controlled residential settings shall have privacy in their living or sleeping unit;
 - c. Individuals sharing units have a choice of roommates in that setting; and
 - d. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

This chapter is intended to give a NOW provider the information needed to fulfill its vendor agreement 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 LDH rules.

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COVERED SERVICES

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

Beneficiaries must receive at least one NOW service every 30 days. **Support coordination is not a covered NOW service.**

Support coordination services includes on-going support and assistance to the beneficiary.

The support coordinator must provide information, assistance, and management of the service being self-directed to beneficiaries that choose to self-direct their waiver services.

Service Limits

Support coordination shall not exceed 12 units. One calendar month constitutes one unit. Virtual visits are permitted; however, the initial and annual POC meeting and at least one other meeting per year must be conducted face-to-face. When a relative living in the home or a legally responsible individual or legal guardian provides a paid NOW service, all support coordination visits must be conducted face-to-face, with no option for virtual visits.

Individual and Family Support

Individual and family support (IFS) services are defined as direct support and assistance provided to a beneficiary in their home or in the community that allow the beneficiary to achieve and/or maintain increased independence, productivity, enhanced family functioning, and inclusion in the community to the same degree as individuals without disabilities. IFS services are also used to provide relief to the primary caregiver. IFS services may not supplant primary care available to the beneficiary through natural and community supports.

IFS services include the following allowable activities:

1. Assistance and prompting with personal hygiene, dressing, bathing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated;

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2. Assistance and/or training in the performance of tasks related to maintaining a safe, healthy, and stable home, such as:
 - a. Housekeeping;
 - b. Laundry;
 - c. Cooking;
 - d. Evacuating the home in emergency situations;
 - e. Shopping; and
 - f. Money management, which includes paying bills.
3. Assistance in participating in community, health, and leisure activities which may include accompanying the beneficiary to these activities;
4. Assistance and support in developing relationships with neighbors and others in the community and in strengthening existing informal social networks and natural supports;
5. Enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences such as volunteer work and community awareness activities; and
6. Accompanying the beneficiary to the hospital and remaining until admission or a responsible representative arrives, whichever occurs first. IFS services may resume at the time of discharge.

The provider is required to utilize the standard POC provider documents specified by Office for Citizens with Developmental Disabilities (OCDD) to identify how the supports will be delivered. Documentation is required of all supports provided to the beneficiary that allows them to meet the goals identified on the approved POC.

Individual and Family Support - Day

Individual and family support – day (IFS – D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the beneficiary. Waking hours are the period of time when the beneficiary is awake and is not limited to traditional daytime hours as outlined in the approved POC. The IFS worker must be awake, alert, and available to respond to the beneficiary’s immediate needs.

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Additional hours of IFS – D beyond the 16 hours may be approved based on documented need, which can include medical or behavioral and specified in the approved POC.

Individual and Family Support - Night

Individual and family support – night (IFS – N) services are the availability of direct support and assistance provided to the beneficiary while the beneficiary sleeps. Night hours are considered the period of time when the beneficiary is asleep and there is reduced frequency and intensity of required assistance.

IFS – N services are not limited to traditional night hours and are documented in the approved POC. The number of IFS – N services for beneficiaries who receive less than 24 hours of paid support is based on need and specified in the POC.

The IFS – N worker must be immediately available and in the same residence as the beneficiary to be able to respond to the beneficiary’s immediate needs. Documentation of the level of support needed, which is based on the frequency and intensity of needs, must be included in the POC with supporting documentation in the provider’s service plan. Supporting documentation shall outline the beneficiary’s safety, communication, and response methodology planned for and agreed to by the beneficiary and/or their authorized representative.

The IFS – N worker is expected to remain awake and alert unless otherwise authorized under the procedures noted below:

1. Beneficiaries who are able to notify direct support workers (DSWs) of their need for assistance during sleeping hours;
2. Support team assesses the beneficiary’s ability to awaken staff. If it is determined that the beneficiary is able to awaken staff, then the approved POC shall reflect the beneficiary’s request that the IFS – N worker be allowed to sleep;
3. Support team should consider the use of technological devices that would enable the beneficiary to notify/awaken IFS – N staff. Examples of devices include wireless pagers, alerting devices such as a buzzer, a bell or a monitoring system. If the method of awakening the IFS – N worker utilizes technological device(s), the service provider will document competency in use of devices by both the beneficiary and IFS – N staff prior to implementation. The support coordinator will require a demonstration of effectiveness of this service on at least a quarterly basis;
4. Review shall include review of log notes indicating instances when IFS – N staff was awakened to attend to the beneficiary and an acknowledgement by the beneficiary that the IFS – N staff responded to their need for assistance timely and

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appropriately. Any instance that indicates the staff did not respond appropriately will immediately be brought to the attention of the support team for discontinuing the allowance of the staff to sleep; and

5. Any allegation of abuse/neglect during sleeping hours will result in discontinuing the allowance of the staff to sleep until an investigation is complete. Valid findings of abuse/neglect during night hours will require immediate revision to the POC.

Shared Supports

IFS – D or IFS –N services can be shared by up to 3 waiver beneficiaries who may or may not live together when the beneficiaries meet the following:

1. Have a common IFS provider agency;
2. Agree to share services; and
3. Assurance is made for each beneficiary’s health and safety.

Service can be in the home of a beneficiary or in the community. The DSW must be present with the beneficiaries, but does not have to be in the same room with all the beneficiaries at the same time. The DSW may move freely between rooms or between indoor and outdoor spaces related to the home in order to assist beneficiaries in their choice of activities.

Shared support in a community-based event requires the DSW to maintain proximity with visual and auditory contact, offering hands-on assistance when appropriate. For example, if the DSW is with 2 beneficiaries at the park, the DSW may be tossing a ball with one beneficiary while maintaining visual/auditory contact with another beneficiary who is sitting on a bench.

The decision to share staff must be reflected on the beneficiary’s POC and based on an individual-by-individual determination and choice with reimbursement rates adjusted accordingly.

Sharing Supports among Roommates

Finding a beneficiary or beneficiaries to share supports within one’s home is based upon the choice and preferences of the beneficiaries involved. Beneficiaries who live together as roommates and who agree to share supports must sign a release of information allowing each beneficiary’s name to be used in the POC, progress notes, individualized service plan (ISP), etc., of the other beneficiaries with whom services are shared.

The POC for beneficiaries sharing supports among roommates include the following:

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1. Completed “Documentation for Authorization of Shared Staff and Release of Information for NOW” form for each beneficiary. (See Appendix D for information on accessing the *Guidelines for Support Planning* found in Section 6 for a copy of this form);
2. POC for each beneficiary that includes the names of the roommates in the “Current Living Situation: Information” section and documentation indicating the risks and benefits of sharing supports has been discussed with the beneficiaries; and
3. Copies of budget sheets and typical weekly schedules of all beneficiaries who will be sharing supports.

NOTE: Budget sheets and POCs must be consistent between the beneficiaries when supports are shared in a shared living setting.

Sharing Supports among Non-Roommates

Beneficiaries who choose to share supports casually (i.e., attend a ballgame, movie, go out to eat together, etc.) are **not** required to sign a release of information form or list the names of the other beneficiaries on the POC. Additionally, the IFS hours can be flexed to allow for casual sharing without a revision to the POC as long as sharing between the beneficiaries is driven by the person and is appropriate. Routine sharing of hours should be budgeted as shared hours in the POC.

Support coordination agencies and IFS provider agencies must follow the policy specified in the *OCDD Guidelines for Support Planning*. (See Appendix D for *Guidelines for Support Planning* information for shared services).

Shared IFS services, hereafter referred to as shared support services, may be either day or night services. In addition, IFS direct support may be shared across the Children’s Choice (CC) Waiver or the Residential Options Waiver (ROW) at the same time.

Transportation

Transportation **is included** in the rate paid to the direct service provider (DSP) with no specified mileage limit. The provider is not allowed to charge the beneficiary, their family member or others a separate fee for transportation.

In the absence of natural or community supports, the provider is responsible for transporting the beneficiary to approved activities as specified in the POC.

The provider is also responsible for providing transportation to unscheduled medical visits required by the beneficiary.

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IFS services may be provided in the beneficiary's home or in the community. IFS may **not** be provided in the following locations:

1. Worker's residence, unless the worker's residence regardless of the relationship, is a certified foster care home;
2. Hospital once the beneficiary has been admitted for inpatient services;
3. Licensed congregate setting. A licensed congregate setting includes licensed intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), community homes, center-based respite (CBR) facilities, and day habilitation programs;
4. Outside the state of Louisiana, but within the United States or its territories, unless there is a documented emergency or a time-limited exception (not to exceed 30 days) which has been prior approved by the local governing entity (LGE) and included in the beneficiary's POC; and
5. Outside the United States or territories of the United States.

NOTE: Time spent on a cruise ship that leaves and returns to the same United States port of call is eligible for IFS services. Time spent off the cruise ship and in a foreign country or territory is not eligible for IFS services. Tickets for these types of trips should not be purchased until a revision to POC has been approved by the LGE. Beneficiary funds are not allowed to be used to purchase travel tickets for DSWs accompanying the beneficiary on the trip without written approval from the LGE.

Standards

Providers must possess a current, valid home and community-based service (HCBS) providers' license to provide personal care attendant (PCA) services and enroll as a Medicaid provider for waiver services or be a DSW providing support under an authorized self-direction option.

Service Exclusions

Beneficiaries who live in distinct residences may not share in-home supports when the beneficiaries are in their own respective homes. This includes beneficiaries who live next door to each other or live in separate apartments within one complex.

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IFS cannot be billed or provided for during the same hours on the same day as:

1. Day habilitation;
2. Supported employment models;
3. Prevocational services;
4. Transportation for habilitation services;
5. Professional services;
6. CBR;
7. Skilled nursing services; and
8. IFS - night/shared.

Additionally, IFS cannot be billed when a beneficiary has been admitted to an in-patient setting, (i.e., hospital, nursing home, psychiatric hospital, etc.). Services can be provided and billed up until the beneficiary is admitted and after the beneficiary is discharged. Documentation from the admitting/discharging facility which documents the time of admit/discharge may be required for services to be reimbursed. See Appendix F for claims filing instructions when a beneficiary has been hospitalized.

The IFS – D or IFS - N worker may not work more than 16 hours in a 24-hour period for a single provider agency unless there is a documented emergency, time limited, non-routine need that is documented in the beneficiary’s approved POC, or approved in writing by the OCDD Waiver Director/designee. Habitual patterns of a worker providing more than 16 hours of paid services per day will be investigated.

Unless an exception is documented in the beneficiary’s approved POC, IFS – D services **may not** exceed 16 hours per calendar day.

IFS – N services must be a minimum of 8 hours for beneficiaries who receive 24 hours of care unless approved by OCDD Central Office and documented in the beneficiary’s approved POC.

Beneficiaries cannot receive more than 24 hours of combined IFS – D and IFS – N services within a 24-hour period.

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The beneficiary and worker must be present in order for the provider to bill for this service. In no instance should a beneficiary be left alone when services are being provided.

Family members who provide IFS services must meet the same standards as providers or direct care staff who are unrelated to the beneficiary. Each person living in the home can work no more than 40 hours per week, Sunday to Saturday.

Legally responsible individuals (such as a parent or spouse) and legal guardians may provide IFS services for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

Authorization for Worker to Exceed 16-Hour Service Limitation

The LGE may approve IFS-D or IFS-N workers to provide services for more than 16 hours in a 24-hour period, which includes a combination of IFS – D and IFS – N services, in the following circumstances:

1. Non-routine, time limited basis when the primary caregiver is unable to provide care to the beneficiary outside the regular IFS hours due to the hospitalization or death of a family member, emergency with another child or family member, business travel, or other documented need. Time limited is defined as one exception per quarter for up to 7 calendar days. Any request beyond this limit must obtain approval from the OCDD Central Office; and
2. Emergency situations that could include hurricane, tornado, flooding, or other natural disaster.

Requests must be made by the beneficiary to the support coordinator. Upon notification of the request, the support coordinator is responsible for submitting a revision request to the LGE by the next business day. Requests must include supporting documentation. The OCDD Waiver director/designee can approve a request to exceed the 16-hour rule without a revision to the POC. Examples include a natural disaster affecting wide spread areas of the state (flooding, hurricane, tornado, etc.).

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

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The provider must bill for all beneficiaries who share supports using the appropriate shared supports codes. The billing submission is required to match among beneficiaries served by the provider.

The use of the Electronic Visit Verification (EVV) system is mandatory for IFS services. The EVV system requires the electronic check in/out in the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OCDD.

Supplemental Payment for Individuals receiving IFS with Complex Needs

Supplemental payment will provide funds for additional support to individuals currently receiving qualified waiver services who have complex medical and/or behavioral needs, and as a result are at a higher risk of institutionalization due to the inability to access waiver provider services, retain direct support staff, or access other professional services not covered by the waiver. The integration of this supplemental payment provides supports that focus on the prevention of deteriorating or worsening medical or behavioral conditions.

The supplemental payment is intended to be time limited to such an extent that the individual supported is expected to progress and become stable due to the service(s). Once stability is achieved, the supplemental payment will be discontinued.

Process for Determination

A Louisiana approved Medicaid provider must routinely provide a minimum of eight hours of IFS services daily to the individual and must complete a screening tool and submit initial documentation prior to qualifying for any supplemental payment.

The individual cannot receive 12 hours or more of skilled nursing services per day. The supplemental payment is not allowed for waiver participants who do not receive IFS services.

Medical:

1. Individual requires at least 2 of the following non-complex nursing tasks on a routine basis to be performed by a DSW in accordance with the DSW Guidelines for Didactic Training. A DSW who has undergone documented, person-specific training on the delegable non-complex tasks required for this individual will perform the following required tasks:
 - a. Suctioning of a clean, well-healed, uncomplicated mature tracheostomy in an individual who has no cardiopulmonary problems and is able to

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- cooperate with the person performing the suctioning (excludes deep suctioning);
 - b. Care of a mature tracheostomy site;
 - c. Removing/cleaning/replacing inner tracheostomy cannula for mature tracheostomy;
 - d. Providing routine nutrition, hydration, or medication through an established gastrostomy or jejunostomy tube (excludes naso-gastrostomy tube);
 - e. Clean intermittent urinary catheterization;
 - f. Obtaining a urinary specimen from a port of an indwelling urinary catheter;
 - g. Changing a colostomy appliance;
 - h. Ensuring proper placement of nasal cannula (excludes initiation/changing of flow rate);
 - i. Capillary blood glucose testing;
 - j. Simple wound care (including non-sterile/clean dressing removal/application); and
 - k. Other delegable non-complex tasks as approved by OCDD.
2. Documented evidence that home health/skilled nursing agencies cannot provide the service via other available options such as the Medicaid State Plan.

Behavioral:

- 1. Individual must meet 2 of the following:
 - a. Specific behavioral programming/procedures are required, or the individual receives behavioral health treatment/therapy and needs staff assistance on a daily basis to complete therapeutic “homework” or use skills/coping mechanism being addressed in therapy;

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- b. Staff must sometimes intervene physically with the individual beyond a simple touch prompt or redirect, or the individual's environment must be carefully structured based on professionally driven guidance/assessment to avoid behavior issues or minimize symptoms; and
 - c. Supervised period of time away, outside of the individual's weekly routine, is needed at least once per week. This may manifest through the presence of severe behavioral health symptoms on a weekly basis that restrict the individual's ability to work, to go to school, and/or to participate in their community.
2. Due to the above items the individual requires one of the following:
- a. "Higher credentialed" staff (college degree, specialized licensing like registered behavioral technician (RBT), applied behavioral analyst (ABA), etc.), who have advanced behavioral training for working with individuals with severe behavioral health symptoms or significant experience working with this population; and
 - b. Need for higher qualified supervision of the direct support of staff (master's degree, additional certification like board certified behavioral analyst (BCBA), etc.) **and** the expertise is not available through other professionals/services.

Documentation requirements are defined in Section 32.8, Record Keeping of this manual chapter.

Center-Based Respite

CBR service is temporary short-term care provided to a beneficiary who requires support and/or supervision in their day-to-day life due to the absence or relief of the primary caregiver.

The beneficiary's routine is maintained while receiving CBR service so that they are able to attend school, work, or other community activities and outings. Community outings shall be specified in the beneficiary's approved POC and shall include activities the beneficiary would receive if they were not in CBR care.

Transportation

The CBR provider is responsible for transporting the beneficiary to community outings, such as work, school, etc., as this is included in the service rate. There is no mileage limit specified for this service.

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Standards

Providers must possess a current, valid HCBS providers' license to provide respite as a CBR facility and enroll as a Medicaid waiver provider.

Service Exclusions

The cost of room and board is not included in the reimbursement paid to the CBR provider.

Service Limitations

CBR services shall not exceed 720 hours (2,880 1/4 hours units) per beneficiary per POC year unless approval is given by OCDD Central Office.

CBR services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation;
2. Supported employment models;
3. Prevocational services
4. Transportation for habilitation services
5. Professional services
6. IFS–day/night/shared
7. Skilled nursing services, or
8. Community integration and development.

Both the beneficiary and a DSW must be present for the provider to bill for this service.

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

The use of the EVV system is mandatory for CBR services. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD.

Community Life Engagement Development

Community life engagement development (CLED) should be utilized for the purpose of development of opportunities to assist individuals in becoming involved in their community and helping to develop a meaningful day for each individual. The purpose is to encourage and foster the development of meaningful relationships and memberships in the community, reflecting the person’s choices and values:

CLED service:

1. Will be person-centered with an outcome of increased community activities and involvement in areas of interest as expressed by the individual;
2. Should include church involvement, civic involvement, volunteering opportunities, as well as recreational activities; and
3. Should be integrated with the community and not segregated groups.

The role of the CLED should be to develop individual activities, memberships and volunteer positions within the beneficiary’s community based off each beneficiary’s person centered plan and expressed interests and desires.

Transportation

The cost of transportation is included in the rate paid to the provider.

Service Limitations

CLED services can be billed at the same time that the beneficiary is receiving a day or employment service:

1. Beneficiary may or may not be present;
2. Billed in 15 minute increments;
3. 240 units per POC year (60 hours) which includes the combination of shared and non-shared CLE; and
4. Services shall not exceed the number of units defined in the beneficiary’s POC and must be prior authorized.

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To utilize this service, the beneficiary may or may not be present as identified in the approved POC.

Residential Habilitation – Supported Independent Living

Residential habilitation – supported independent living (SIL) services assist beneficiaries, aged 18 years or older, to acquire, improve, or maintain social and adaptive skills necessary to enable them to reside in the community and to participate as independently as possible.

SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping, money management and bill paying. SIL services may serve to reinforce skills or lessons taught in school, therapy or other settings. Beneficiaries receiving SIL services have the right to control their personal resources, and are not required to designate the provider agency as their representative payee. This includes payments to beneficiaries from supported employment or other employment sources.

SIL services also assist beneficiaries in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff, and accessing other programs for which they qualifies. SIL services also assists with Medicaid eligibility renewals as needed.

Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. The service plan should include initial, introduction, and exploration for positive outcomes for the beneficiary for community integration development.

Place of Service

The setting for SIL services must be integrated in the greater community, and support full access to the community by the beneficiary. If housing assistance is provided, the setting shall be selected from among setting options, including non-disability specific settings, and an option for a private unit. The settings options offered must be documented in the beneficiary’s person specific POC and be based on the individual’s needs, preferences, and resources available, and must allow the right to privacy in their living unit or bedroom. Additionally, the settings must provide protection from eviction through a lease agreement that provides protections that address eviction processes and appeals comparable to the state’s landlord tenant law. The residential unit shall have doors lockable by the beneficiary (unless contraindicated due to health and safety and documented in the POC) with only appropriate staff having keys to doors. If sharing residential services, the beneficiary shall have choice with whom to share. Beneficiaries will have the freedom to furnish and decorate their sleeping or living units as allowed in the lease/agreement.

Services are provided in the beneficiary’s place of residence and/or in the community. The beneficiary’s residence includes their apartment or house, not the residence of a legally responsible

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relative. An exception will be **considered** when the beneficiary lives in the residence of a legally responsible relative who is age 70 or older or who is disabled.

Provider-owned property where services are delivered must be compliant with the Americans with Disabilities Act (ADA) as applicable to the beneficiary’s individual needs.

Beneficiaries must be able to choose to receive supports from any provider on the Freedom of Choice (FOC) list in their region. When an SIL provider owns or leases property to a beneficiary, the provider shall not terminate or refuse to renew a beneficiary’s lease based solely on the beneficiary’s choice of utilizing another provider for their service delivery. A beneficiary’s lease shall not be tied to a provider’s service agreement.

NOTE: A legally responsible relative is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the beneficiary’s spouse.

SIL services **cannot** be provided in the following settings:

1. Substitute Family Care (SFC) home; or
2. CBR facility.

Standards

Providers must possess a current, valid HCBS providers’ license to provide supervised independent living services and enroll as a Medicaid waiver provider.

Service Exclusions

Legally responsible persons may not be SIL providers to the person for whom they have legal responsibility. Payment for SIL does not include payments made directly or indirectly to the members of the beneficiary’s immediate family.

SIL does not include the cost of the following:

1. Meals or the supplies needed for meal preparation;
2. Room and board;
3. Home maintenance or upkeep and improvement;
4. Routine care and supervision which could be expected to be provided by a family member; or

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5. Activities or supervision for which a payment is made by a source other than Medicaid (e.g. OCDD).

Service Limitations

SIL services are limited to one service per day per POC year, except when the beneficiary is in CBR care. When a beneficiary living in an SIL setting is admitted to a CBR facility, the SIL provider is not allowed to bill the SIL per diem beginning with the date of admission to the center and through the date of discharge from the respite center.

No more than three people can live together and share an SIL setting unless they are related or have been granted an exception by the OCDD Assistant Secretary or their designee.

The SIL service is not available to beneficiaries in the self-direction option, as these beneficiaries are responsible for directing their own care.

Reimbursement

The service unit is one per day per POC year and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

The use of the EVV system is mandatory for the monthly face-to-face SIL visit in the home. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD.

Substitute Family Care

SFC is a stand-alone family living arrangement for beneficiaries, aged 18 years or older, in which the SFC house parents assume the direct responsibility for the beneficiary's physical, social, and emotional well-being and growth, including family ties. The SFC home must meet all licensing requirements for the SFC module.

SFC provides beneficiaries who live in an SFC home with the following:

1. Day programming;
2. Transportation;
3. Independent living training;

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4. Community integration;
5. Homemaker;
6. Chore;
7. Attendant care and companion services; and
8. Medication oversight (to the extent permitted under state law).

Beneficiaries living in an SFC home may receive IFS and other services through the NOW. The provider is required to prepare POC provider documents for the provision of SFC services based on the beneficiary’s approved POC. Beneficiaries receiving SFC services have the right to control their personal resources, and are not required to designate the provider agency or the SFC caregiver as their representative payee. This includes payments to beneficiaries from supported employment or other employment sources. Additionally, beneficiaries have the right to privacy in their living unit or bedroom with doors lockable by the individual unless contraindicated in the POC. If sharing residential services, the beneficiary shall have choice with whom to share. Beneficiaries will have the freedom to furnish and decorate their sleeping or living units.

Standards

Providers must possess a current, valid HCBS providers’ license with the SFC services module and enroll as a Medicaid waiver provider.

Service Exclusions

SFC services do not include payment for room and board, items of comfort or convenience, facility maintenance, upkeep and improvement, or payments made directly or indirectly to members of the beneficiary’s immediate family.

SFC homes shall not be SIL settings.

Service Limitations

Only 2 SFC beneficiaries can reside in a single SFC setting at the same time. There shall be no more than 3 persons living in a SFC setting who are unrelated to the SFC family. Immediate family members (spouse, mother, father, brother and/or sister) cannot be SFC parents. Reimbursement for this service includes the development of a service plan based on the approved POC.

SFC services cannot exceed 365 days per year.

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The service unit is one service per day and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

Day Habilitation

Day habilitation services:

1. Provide beneficiaries, aged 18 years or older, with assistance in developing social and adaptive skills necessary to enable them to participate as independently as possible in the community. Day habilitation services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness;
2. Provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the person's residence and are not limited to a fixed-site facility. Interactions with beneficiaries are expected to be respectful and protect the individual's right of privacy for personal care issues as well as interactions or situations involving any aspect of the individual's care and support;
3. Must be directed by a service plan that has been developed by the provider to address the beneficiary's POC goals, and to provide the beneficiary a choice in how they spend their day. The activities should assist the beneficiary to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to and be a part of their community; and
4. Must be coordinated with any physical, occupational, or speech therapies, prevocational services or employment listed in the beneficiary's approved POC, and may serve to reinforce skills or lessons taught in school, therapy, or other settings to attain or maintain the beneficiary's maximum functional level. The beneficiary does not receive payment for the activities in which they are engaged.

Some examples of day habilitation services include, but are not limited to, the following:

1. Career planning activities may be a component of the beneficiary's plan and may be used to develop learning opportunities and career options consistent with the person's skills and interests;

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2. Assisting and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs, and any medical task which can be delegated. Personal care assistance may not comprise the entirety of this service;
3. Receiving personal care skills training at a facility to improve their adaptive skills;
4. Participating in a community inclusion activity designed to enhance the beneficiary's social skills;
5. Training in basic nutrition and cooking skills at a community center;
6. Participating, for an older beneficiary, with a group of senior citizens in a structured activity. This may include activities such as community-based activities sponsored by the local Council on Aging (COA);
7. Receiving aerobic aquatics in an inclusive setting to maintain the beneficiary's range of motion;
8. Learning how to clean a residence;
9. Learning how to make choices and ordering from a fast food restaurant;
10. Learning how to observe basic personal safety skills;
11. Doing non-paid work in the community alongside peers without disabilities to improve social skills and establish connections; and
12. Receiving, as appropriate with their family, information and counseling on benefits planning and assistance in the process.

Transportation

Transportation services (including wheelchair) are a separate, billable component of day habilitation. Transportation may be provided to and/or from the beneficiary's residence or a location agreed upon by the beneficiary or authorized representative.

Place of Service

Day habilitation services are provided in a non-residential community setting, separate from the home in which the beneficiary resides.

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Providers must possess a current, valid HCBS providers' license to provide adult day health care (ADHC) services and enroll as a Medicaid waiver provider.

Service Limitations

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for service procedure code/rate information).

Day habilitation services may be provided one or more hours per day, not to exceed 8 hours per day or 2,080 hours per beneficiary per POC year.

The provider may only bill for transportation for the date(s) which the beneficiary received day habilitation services as indicated in the approved POC.

Both the beneficiary and the DSW must be present in order for the provider to bill for this service.

Services cannot be provided or billed for during the same hours on the same day as:

1. Supported Employment models;
2. Employment-Related Training;
3. Professional Services;
4. IFS – Day/Night/Shared;
5. Community Integration and Development; or
6. CBR.

Reimbursement Requirements

The use of the EVV system is mandatory for day habilitation services. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD. Day habilitation transportation is exempt from this mandatory requirement.

Supported Employment

Supported employment is competitive work, for individuals who are eligible and assessed to need the service. The service is delivered in an integrated work setting, or employment in an integrated work setting in which the individuals are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of individuals for whom competitive employment has not traditionally occurred.

These services are provided to individuals who are **not** served by Louisiana Rehabilitation Services, need more intense, long-term follow along and usually cannot be competitively employed because supports cannot be successfully phased out.

Supported employment consists of intensive, ongoing supports that enable beneficiaries, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities need supports to perform in a regular work setting.

Supported employment includes activities needed to sustain paid work by beneficiaries, including supervision and training, as specified in the beneficiary's POC. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Supported employment services also includes:

1. Assistance and prompting with personal hygiene;
2. Dressing;
3. Grooming;
4. Eating;
5. Toileting;
6. Ambulation or transfers;
7. Other personal care and behavioral support needs; and
8. Any medical task which can be delegated.

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Personal care assistance may not comprise the entirety of this service. Interactions with beneficiaries are expected to be respectful and protect the individual's right of privacy for personal care issues as well as interactions involving any aspect of the individual's care and support.

Types of Supported Employment Services

Reimbursement for supported employment includes an ISP for each of the following models.

Individual Placement or One-to-One Model

A one-to-one model is a placement strategy in which an employment specialist (job coach) places a beneficiary into competitive employment, provides training and support, and then gradually reduces time and assistance at the work site once a certain percentage of the job is mastered by the beneficiary. The beneficiary may then be transitioned to the Follow Along model of Supported Employment.

A beneficiary can move from the Follow Along model back to the One-to-One intensive model if the job changes or a new job has been secured for the beneficiary and new tasks have to be learned.

Follow Along

Follow Along services are designed for persons only requiring minimum oversight to maintain the beneficiary at the job site. Ongoing support services can be provided from more than one source.

Mobile Work Crew/Enclave

Mobile work crew/enclave is an employment setting in which a group of 2 or more beneficiaries, but no more than 8 perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). The beneficiaries may be dispersed throughout the company and among workers, or congregated as a group in one part of the business.

Supported employment group must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces.

Transportation

Transportation is an allowable activity within individual supported employment, but whenever possible, family, neighbors, friends, co-workers or community resources that can provide needed transportation without charge should be utilized.

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Transportation is a separate, billable component of this service by the provider, but it must be billed on the same day as the group employment service is delivered.

Participants receiving supported employment, group services may also receive other services including prevocational or day habilitation services, but these services cannot be provided in the same day.

Place of Service

Supported employment is conducted in a variety of settings, in particular at work sites in which persons without disabilities are employed.

Standards

The provider must possess a valid certificate of compliance as a Community Rehabilitation Provider (CRP) from Louisiana Rehabilitation Services or have a current valid HCBS providers' license to provide supported employment services and 15 hours of documented initial and annual vocational-based training.

Transportation providers must possess a current valid HCBS providers' license to provide supported employment services and enroll as a Medicaid waiver provider.

Service Exclusions

Supported employment services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation;
2. Prevocational services;
3. Professional services;
4. IFS – day/night/shared; or
5. CBR.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by beneficiaries receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

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Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) [20 U.S.C. 1401 (26) and (29)].

Reimbursement Requirements

The use of the EVV system is mandatory for all supported employment services except supported employment transportation. The EVV system requires the electronic check in/out in LaSRS® or another EVV system approved by BHSF and OCDD.

Service Limitations

Supported Employment Model	Annual Limits	Weekly Limit	Daily Limit
One-to-One	1,280 ¼ hour units/year	5 days/week	8 hours/day
Follow Along	24 days per POC year		
Mobile Crew/Enclave	8,320 ¼ hour units per POC year without additional documentation	5 days/week	8 hours/day

Reimbursement

Supported Employment Model	Service Unit
One-to-One	15 minutes
Follow Along	1 unit per day
Mobile Work Crew/Enclave	15 minutes

NOTE: See Appendix E for service procedure code/rate information.

The provider may only bill for transportation for the date(s) which the beneficiary received supported employment services as indicated in the approved POC.

Prevocational Services

Prevocational services are intended to prepare a beneficiary for paid employment or volunteer opportunities in the community to the beneficiary’s highest level. Prevocational services allow the individual to develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

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Prevocational services are intended to develop and teach general skills such as:

1. Ability to communicate effectively with supervisors, co-workers, and customers;
2. Accepted community workplace conduct and dress;
3. Ability to follow directions and attend to tasks;
4. Workplace problem solving skills and general workplace safety;
5. Mobility training;
6. Observation of an employee of an area business to obtain information to make an informed choice regarding vocational interest;
7. Instruction on how to use work-related equipment;
8. Assistance in planning appropriate meals for lunch while at work;
9. Instruction on basic personal finance skills; and
10. Information and counseling to a beneficiary and, as appropriate, their family on benefits planning and assistance in the process.

Prevocational services are provided in a variety of locations in the community and are not limited to a fixed-site facility. Beneficiaries receiving prevocational services must have an employment related goal as part of their POC and service plan. The general habilitation activities must support their employment goals. Prevocational services are designed to create a path to integrated community based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Assistance with personal care may be a component of prevocational services, but may not comprise the entirety of the service.

The beneficiary may be paid for engaging in this service, according to federal regulations, by the prevocational services provider. If a beneficiary is paid above 50 percent of the minimum wage, there must be a review every 6 months to determine the suitability of this service rather than supported employment services.

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The provider is responsible for all transportation between prevocational sites.

Transportation services (including wheelchair) are a separate, billable as a component of prevocational services. Transportation may be provided to and/or from the participant's residence or a location agreed upon by the participant or authorized representative.

Standards

Providers must possess a current, valid HCBS Providers license to provide ADHC services and enroll as a Medicaid waiver provider.

Service Exclusions

Services are not available to beneficiaries who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of IDEA [20 U.S.C. 1401(26) and (29)].

Service Limitations

Services must not exceed 8 hours a day, 5 days per week, and cannot exceed 8,320 ¼ hour units of service per POC.

Prevocational services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation;
2. Supported employment models;
3. Professional services;
4. IFS – day/night/shared; or
5. CBR.

Reimbursement

The service unit is 15 minutes. (See Appendix E for service procedure code/rate information).

Billing for this service is only allowed when the beneficiary and a DSW were both present.

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The use of the EVV system is mandatory for all employment-related training services. The EVV system requires the electronic check in/out in the LaSRS® or another EVV system approved by BHSF and OCDD.

Environmental Accessibility Adaptations (EAA)

Environmental accessibility adaptations (EAAs) are physical modifications to the private residence or vehicle of the beneficiary or their family that are necessary to ensure the health, welfare, and safety of the beneficiary or that enable the beneficiary to function with greater independence in the home and/or community, and without these services, the beneficiary would require additional supports or institutionalization.

EAAs may include, but are not limited to, the following:

1. Installation of non-portable ramps and grab-bars;
2. Widening of doors;
3. Modification of bathroom facilities;
4. Installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies for the welfare of the beneficiary; and
5. Adaptations to the vehicle may include a lift, or other adaptations to make the vehicle accessible to the beneficiary, or for the beneficiary to drive.

Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the LGE prior to the modifications being made.

Standards

Providers must be enrolled as a Medicaid waiver service provider and comply with applicable state and local laws governing licensure and/or certification.

All EAA providers must be registered with the Louisiana State Licensing Board for Contractors as a home improvement contractor, with the exception of providers of vehicle adaptations.

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

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

Service Exclusions

Excluded are those adaptations or improvements to the home that are of general utility or maintenance and are not of direct medical or remedial benefit to the beneficiary, including, but not limited to the following:

1. Flooring (carpet, wood, vinyl, tile, stone, etc.);
2. Interior/exterior walling not directly affected by a modification;
3. Lighting or light fixtures, which are for non-medical use;
4. Furniture;
5. Roofing, installation or repairs, this also includes covered ramps, walkways, parking areas, etc.;
6. Air conditioning or heating (solar, electric, or gas; central, floor, wall, or window units, heat pump-type devices, furnaces, etc.);
7. Exterior fences or repairs made to any such structures;
8. Motion detector or alarm systems for fire, security, etc.;
9. Fire sprinklers, extinguishers, hoses, etc.;
10. Pools;
11. Smoke and carbon monoxide detectors;
12. Interior/exterior non-portable oxygen sites;
13. Replacement of toilets, septic system, cabinets, sinks, counter tops, faucets, windows, electrical or telephone wiring, or fixtures when not affected by a

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modification, not part of the installation process, or not one of the pieces of medical equipment being installed;

14. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, whole home electrical generators, etc.);
15. Adaptations, which add to the total square footage or add total living area under the roof of the residence;
16. Repairs to the home or adaptations to the vehicle provided under the NOW; or
17. Repairs or modifications provided to previously installed home or vehicle modifications not provided under the NOW.

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

Modifications to the home shall meet all applicable state and local building or housing code standards.

Car seats are not considered as a vehicle adaptation.

Also excluded are any items covered under the Medicaid State Plan.

Service Limitations

There is a cap of \$12,000 per beneficiary for EAA for a 3-year period.

Authorization to Exceed Cap

On a case-by-case basis, with supporting documentation and based on need, a beneficiary may exceed the cap with prior approval from the OCDD Central Office. Supporting documentation may include the following:

1. Three competitive bids;
2. Reason why additional bids were not obtained;
3. Other funding resources contacted for assistance;

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4. Amount of increased supports needed due to not receiving the additional funding for the EAA;
5. Amount of decreased supports needed due to receiving the additional funding for the EAA; or
6. Inability of the beneficiary to personally fund the item.

The submitting LGE must describe the impact on the health and safety of the individual if the additional funding is not approved including the outcome if required to wait until budget allows for additional expenditures.

The support coordinator will assist the beneficiary in completing the necessary forms to request this approval.

Reimbursement

Items reimbursed through NOW funds shall be supplemental to any adaptations furnished under the Medicaid State Plan.

A written, itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted to the LGE for prior authorization (PA). The support coordinator will assist the beneficiary in completing the “EAA Job Completion Form” (see Appendix D for a copy of this form) and any other associated documentation to request PA. The LGE must approve the request prior to any work being initiated.

The EAA must be accepted by the beneficiary, fully delivered, installed, and operational, in the current POC year in which it was approved. It must be billed for reimbursement within the timely filing guidelines established for Medicaid reimbursement. Payment will not be authorized until written documentation which demonstrates that the job is completed to the satisfaction of the beneficiary has been received by the support coordinator. If the adaptation is not accepted by the beneficiary, then OCDD Central Office will request the LGE contact the beneficiary to mediate the issue to a final resolution.

Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation, and all warranty certificates from the manufacturers. The warranty for labor and installation must cover a period of at least 6 months.

The support coordinators must contact the LGE before approving modifications for a beneficiary leaving an ICF/IID).

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Incontinence Supplies

Incontinence supplies including disposable diapers/ briefs, underwear/pull-on, bladder control pads, reusable and disposable under pads, liners, shield guards, disposable and reusable protective underwear, disposable penile wrap and other medically necessary incontinence products for individuals adults age 21 and older not cover under Medicaid State Plan:

1. Does not cover items that have been denied through Durable Medical Equipment (DME) and other programs for lack of medical necessity; and
2. To receive incontinence supplies, the beneficiary must have the following:
 - a. Documentation of medical necessity or current 90L;
 - b. Request for Incontinence Supplies form signed by physicians, physician assistant, or nurse practitioner (NP);
 - c. Prescription from a physician, physician assistant, or NP; and
 - d. PA.

Service Limitations

Annual maximum cost is \$2500/POC year without exception.

Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies (SMES) are specified devices, controls, or appliances, which enable beneficiaries to increase their ability to perform the activities of daily living (ADL), ensure safety, or perceive, control, and communicate with the environment in which they live.

SMES include medically necessary durable and nondurable medical equipment not covered under the Medicaid state plan. The NOW program will not cover items that are not considered medically necessary. SMES may include the following:

1. Sip and puffer switches;
2. Specialized switches;
3. Voice activated, light activated, or motion activated devices to access the beneficiary's environment;

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4. Portable electrical generators for beneficiaries whose medical condition warrants such an item, such as beneficiaries who require ventilators;
5. Items medically necessary for life support; and
6. Ancillary supplies and equipment necessary for the proper functioning of medically necessary items.

SMES may also be used for routine maintenance or repair of specialized equipment. All items shall meet applicable standards of manufacture, design, and installation. Pictures, brochures, and or other descriptive information must accompany the “SMES Purchase and Repair Form” and must be approved by the LGE. PA must be received prior to purchase/maintenance/repair. (See Appendix D for a copy of this form).

Standards

The provider must also be enrolled as a Medicaid waiver provider.

All agencies who are vendors of technological equipment and supplies must be enrolled in the Medicaid program as an assistive devices provider and must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.

Service Exclusions

Excluded are those equipment and supplies that are of general utility or maintenance and are not of direct medical or remedial benefit to the beneficiary, such as:

1. Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, whole-home electrical generators, etc.);
2. Daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, Q-tips, etc.);
3. Rent subsidy;
4. Food, bed covers, pillows, sheets etc.;
5. Swimming pools, hot tubs etc.;
6. Eye exams;

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7. Athletic and tennis shoes;
8. Automobiles;
9. Van lifts for vehicles that do not belong to the beneficiary or their family;
10. Adaptive toys or recreation equipment (swing set, etc.);
11. Personal computers and software;
12. Exercise equipment;
13. Taxi fares, intra and interstate transportation services, and bus passes;
14. Pagers, including monthly service;
15. Telephones, including mobile telephones and monthly service; and
16. Home security systems, including monthly service.

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

Technology Supports with Remote Features

Mobile Emergency Response System is an on-the-go mobile medical alert system, used in and outside the home. This system has cellular/global positioning system (GPS) technology, two-way speakers and no base station required.

Medication Reminder System is an electronic device programmed to remind individual to take medications by a ring, automated recording or other alarm. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser. Medications must be set up by a registered nurse (RN).

Other equipment used to support someone remotely may include but not limited to:

1. Electronic motion door sensor devices;

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2. Door alarms;
3. Web-cams;
4. Telephones with modifications (large buttons, flashing lights);
5. Devices affixed to wheelchair or walker to send alert when fall occurs;
6. Text-to-speech software;
7. Intercom systems;
8. Tablets with features to promote communication; or
9. Smart device speakers.

Remote Technology Service Delivery covers monthly response center/remote support monitoring fee and tech upkeep (no internet cost coverage).

Remote Technology Consultation is the evaluation of tech support needs for an individual, including the functional evaluation of technology available to address the assess needs and support the individual to achieve outcomes identified in the POC.

Service Limitations

There is a cap of \$5,000 per beneficiary for SMES for a 3-year period.

Authorization to Exceed Cap

On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with prior approval from the OCDD Central Office. The support coordinator will assist the beneficiary in completing the necessary forms to request approval.

Supporting documentation may include the following:

1. Three competitive bids;
2. Reason why additional bids were not obtained;
3. Other funding resources contacted for assistance;

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4. Amount of increased supports needed due to not receiving the additional funding for the SMES;
5. Amount of decreased supports needed due to receiving the additional funding for the SMES; or
6. Inability of the beneficiary to personally fund the item.

The submitting LGE must describe the impact on the health and safety of the individual if the additional funding is not approved including the outcome if required to wait until budget allows for additional expenditures.

Personal Emergency Response Systems

A Personal Emergency Response System (PERS) is a rented electronic device that enables beneficiaries to secure help in an emergency. PERS services are available to beneficiaries who meet the following criteria:

1. Have a demonstrated need for quick emergency back-up;
2. Unable to use other communication systems as the systems are not adequate to summon emergency assistance; or
3. Do not have 24-hour direct supervision (such as IFS or other paid supports).

The beneficiary may wear a portable "help" button to allow for mobility. The PERS is connected to the person's phone and programmed to signal a response center to secure help in an emergency once the "help" button is activated. The response center is staffed by trained professionals.

PERS services include the cost of maintenance and training the beneficiary to use the equipment.

Mobile Emergency Response System is an on-the go mobile medical alert system, used in and outside the home. This system will have cellular/GPS technology, 2-way speakers and no base station will be required.

Standards

The provider must be an enrolled Medicaid provider of PERS. The provider shall install and support PERS equipment in compliance with all applicable federal, state, parish and local laws and meet manufacturer's specifications, response requirements, maintenance records and beneficiary education.

Service Limitations

Coverage of the PERS is limited to the rental of the electronic device.

Reimbursement

Reimbursement will be made for a one-time installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS. (See Appendix E for service procedure code/rate information).

Professional Services

Professional services are designed to increase the beneficiary's independence, participation and productivity in the home, work and community. Beneficiaries, up to the age of 21, who participate in the NOW program must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Professional services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid State Plan, including services available through the individual's Medicaid managed care organization (MCO).

Professional services may be utilized for the following:

1. Performing assessments and/or re-assessments and recommendations;
2. Providing consultative services and recommendations;
3. Providing training or therapy to an individual and/or their natural and formal supports necessary to either develop critical skills that may be self-managed by the beneficiary or maintained according to the beneficiary's needs;
4. Intervening in and stabilizing a crisis situation, behavioral or medical that could result in the loss of HCBS; or
5. Providing necessary information to the beneficiary, family, caregivers and/or team to assist in the implementation of plans according to the approved POC.

Professional services include psychological, social work, and nutritional services that assist the beneficiary, and unpaid/paid caregivers in carrying out the approved POC and which are necessary to improve the beneficiary's independence and inclusion in their community. Service intensity, frequency, and duration will be determined by individual need.

Psychological Services

Psychological services are direct services performed by a licensed psychologist (Ph.D.), as specified by State law and licensure. These services are for the treatment of behavioral or mental conditions that address personal outcomes and goals desired by the beneficiary and their support team. Services must be reasonable and necessary to preserve, improve, or maintain adaptive behaviors or to decrease maladaptive behaviors of the beneficiary.

Psychological services include the following:

1. Counseling (a variety of techniques and procedures used by the therapist, e.g., structuring and reinforcement, social modeling, and functional activities);
2. Behavior evaluation for the purpose of therapy;
3. Intervening and stabilizing a crisis situation;
4. Ongoing therapeutic support;
5. Ongoing behavior training for staff and/or families;
6. Administering and interpreting tests and measurements within the scope of practice of behavior therapy;
7. Administering, evaluating, and modifying treatment and consulting within the scope of practice of behavior therapy;
8. Adapting environments specifically for the beneficiary; and
9. Consultative services and recommendations.

Social Work Service

Social work service is highly specialized direct counseling furnished by a licensed clinical social worker (LCSW), designed to meet the unique counseling needs of beneficiaries with developmental disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address the beneficiary's personal outcomes and goals listed in their approved POC.

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Nutritional/dietary service is a medically necessary service that has been ordered by a physician to be provided by a licensed registered dietician or licensed nutritionist directly to the beneficiary. Service may address health care and nutritional needs related to prevention and primary care activities, treatment and diet.

Nutritional/dietary service may include planning food and nutrition programs to help prevent and treat illnesses by promoting healthy eating habits through education, evaluating the beneficiary's diet, and as necessary suggesting modifications to the beneficiary's diet.

Reimbursement will be available for the service provided directly to the beneficiary by a dietician or nutritionist and not for the supervision of a dietician or nutritionist who is performing the hands-on service.

Standards

Professionals rendering service(s) must possess a current valid Louisiana license to practice with one-year post licensure experience in their field of expertise. The professional may be employed by or contracted with the HCBS Provider (PCA) module, or SIL module) agency, or home health agency to provide this service.

Providers must be licensed by the Louisiana Department of Health (LDH) and enrolled as a waiver service provider of PCA, SIL, or home health services.

Agencies enrolled as both SIL and PCA provider types shall bill these professional services under their PCA number in accordance with the requirements of the fiscal intermediary (FI). Agencies enrolled as only SIL or home health providers shall bill under their SIL or home health provider number.

Service Exclusions

The following activities are not reimbursable:

1. Friendly visiting;
2. Attending meetings;
3. Time spent on paperwork or travel;
4. Time spent writing reports and progress notes;

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5. Time spent on billing of services; and
6. Other non-Medicaid reimbursable activities such as time spent on general staff training not related to training for the natural or paid support regarding the beneficiary's POC.

Additionally, services available through the State Medicaid Plan must be exhausted prior to accessing professional services.

Service Limitations

There is a \$2,250 cap per beneficiary per POC year for the combined range of professional services in the same day but not at the same time.

A beneficiary may receive 2 or more professional services on the same day; however, these 2 or more professional services will not be authorized at the same time.

Professional services are limited to psychological, social work, and nutritional/dietary services.

Professional services cannot be provided or billed for during the same hours on the same day as:

1. Day habilitation;
2. Transportation for day habilitation;
3. Supported employment models;
4. Transportation for supported employment models;
5. Prevocational services;
6. IFS – day/night/shared;
7. Skilled nursing services; or
8. CBR.

In order to bill for this service, the beneficiary must be present when the professional rendered the service.

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The service unit is 15 minutes.

Skilled Nursing

Skilled nursing is medically necessary nursing services ordered by a physician and provided by a RN or a licensed practical nurse (LPN) licensed to practice in the state of Louisiana. Skilled nursing must be provided by a licensed, enrolled home health agency and requires an individual nursing service plan, and must be included in the beneficiary's approved POC.

Skilled nursing is designed to meet the needs of the beneficiary, to prevent institutionalization, and teach the beneficiary and/or family necessary medical or related interventions, such as medication management, as ordered by a physician.

Nursing consultations are offered on an individual basis only. Nurse consultations are available to beneficiaries who require short term nursing consultations for family training, skill development etc., as specified in the beneficiary's approved POC.

All Medicaid State Plan services must be utilized before accessing this service. Beneficiaries under the age of 21 must access skilled nursing services as outlined on the POC through the EPSDT Program.

Shared Supports

Skilled nursing may be shared when there is more than one beneficiary in the home receiving these services. Payment for shared services must be coordinated with the service authorization system and specified in each beneficiary's approved POC.

Standards

The provider must possess a current valid license as a home health agency by the LDH and be enrolled as a Medicaid waiver provider of home health.

Service Exclusions

Skilled nursing will not be reimbursed when the beneficiary is in a hospital or other institutional setting.

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Service Limitations

Skilled nursing cannot be provided or billed for during the same hours on the same day as:

1. Transportation for day habilitation;
2. Transportation for supported employment;
3. Professional services;
4. IFS – day/night/shared; or
5. CBR.

Both the beneficiary and the nurse must be present in order for the provider to bill for this service.

Authorization to Exceed 12-Hour Skilled Nursing Service Cap

Requests for 12 hours or less per day of skilled nursing may be approved by the LGE. All requests received for more than 12 hours per day must be approved by the LDH Medical Director and Medical Evaluation Team and will be forwarded to the LGE by the OCDD Central Office for processing. A request to increase the number of hours per day above the number of hours already approved requires the primary care physician to document the medical change(s) of the beneficiary necessitating the increase in the request for nursing services.

Reimbursement

The service unit is 15 minutes.

One – Time Transitional Expenses

One – time transitional expenses are non-reoccurring set-up expenses for beneficiaries, aged 18 years or older, who are transitioning from an ICF/IID or other institution, to their own home or apartment in the community of their choice. Beneficiaries have the right to choose the furnishings for their home or apartment purchased with these funds.

The beneficiary’s home is defined as the beneficiary’s own residence and does not include the residence of any family member or a SFC home.

Allowable transitional expenses include the following:

1. Purchase of essential furnishings such as:

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- a. Bedroom and living room furniture;
- b. Table and chairs;
- c. Window blinds;
- d. Eating utensils;
- e. Food preparation items; and
- f. Bed/bath linens.

NOTE: Purchased items belong to the beneficiary and may not be misused or sold under any circumstances.

- 2. Moving expenses required to occupy and use a community domicile;
- 3. Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy; and
- 4. Nonrefundable security deposits and set-up fees (i.e. telephone, utility, heating by gas) which are required to obtain a lease on an apartment or home.

Standards

This service shall only be provided by the LDH OCDD state office with coordination of appropriate entities.

Service Exclusions

The following expenses are not covered under one-time transitional services:

- 1. Payments for housing or rent;
- 2. Payments for regular utility charges;
- 3. Household appliances/items that are intended for purely recreational purposes;
- 4. Refundable security deposits;
- 5. Food purchases; and
- 6. Payment of furnishing living arrangements that are owned or leased by a waiver

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provider where the provision of these items and services are inherent to the service they are already providing.

Service Limitations

One-time transitional expenses have a life time limit of \$3,000 per beneficiary. Service authorization and transitional expenses are time limited.

Adult Companion Care

Adult companion care services assist the beneficiary to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for an individual who lives independently and can manage their own household with limited supports. The companion is a principal care provider chosen by the beneficiary, who provides services in the beneficiary's home and lives with the beneficiary as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the beneficiary's POC. This service includes the following:

1. Providing assistance with all of the ADL as indicated in the beneficiary's POC;
2. Providing community integration and coordination of transportation services, including medical appointments; and
3. Providing medical and physical health care that can be delivered by unlicensed persons in accordance with Louisiana's Nurse Practice Act.

Adult companion care services are arranged by provider organizations that are subject to licensure. The setting is the beneficiary's home which should have been freely chosen by the beneficiary from among non-disability specific settings and not owned or controlled by the provider. The companion is an employee or contractor of the provider organization and is responsible for providing limited, daily direct services to the beneficiary.

1. The companion shall be available in accordance with a pre-arranged time schedule and available by telephone for crisis support on short notice; and
2. The companion is responsible for participating in, and abiding by, the POC; maintaining records in accordance with state and provider requirements; and purchasing their own food and personal care items.

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Service Limits

Adult companion care services may be authorized for up to 365 days per year as documented in the beneficiary’s POC.

Service Exclusions

Adult companion care services cannot be provided or billed for at the same time as respite care services.

Beneficiaries receiving adult companion care services are not eligible for receiving the following services:

1. SIL;
2. IFS;
3. SFC; or
4. Skilled nursing.

Standards

Provider Qualifications

Providers must be licensed by the LDH as a HCBS provider and must meet the module specific requirements for the service being provided.

Housing Stabilization Transition Service and Housing Stabilization Service

The following housing support services assist waiver beneficiaries to obtain and maintain successful tenancy in Louisiana’s Permanent Supportive Housing (PSH) program.

Housing Stabilization Transition Service

Housing stabilization transition enables beneficiaries who are **transitioning into a PSH unit**, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. Conducting a housing assessment that identifies the beneficiary’s preferences related to housing (type and location of housing, living alone or living with

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someone else, accommodations needed, and other important preferences), and identifying the beneficiary's needs for support to maintain housing, including:

- a. Access to housing;
 - b. Meeting the terms of a lease;
 - c. Eviction prevention;
 - d. Budgeting for housing/living expenses;
 - e. Obtaining/accessing sources of income necessary for rent;
 - f. Home management;
 - g. Establishing credit; and
 - h. Understanding and meeting the obligations of tenancy as defined in the lease terms.
2. Assisting the beneficiary to view and secure housing as needed. This may include:
- a. Arranging or providing transportation;
 - b. Assisting in securing supporting documents/records;
 - c. Assisting in completing/submitting applications;
 - d. Assisting in securing deposits; and
 - e. Assisting in locating furnishings.
3. Developing an individualized housing support plan based upon the housing assessment that:
- a. Includes short and long-term measurable goals for each issue;
 - b. Establishes the beneficiary's approach to meeting the goal(s); and
 - c. Identifies where other provider(s) or services may be required to meet the goal(s).
4. Participating in the development of the POC and incorporating elements of the housing support plan; and
5. Exploring alternatives to housing if PSH is unavailable to support completion of the transition.

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

1. Conducting a housing assessment that identifies the beneficiary's preferences related to housing (type and location of housing, living alone or living with someone else, accommodations needed, and other important preferences), and identifying the beneficiary's needs for support to maintain housing, including:
 - a. Access to housing;
 - b. Meeting the terms of a lease;
 - c. Eviction prevention;
 - d. Budgeting for housing/living expenses;
 - e. Obtaining/accessing sources of income necessary for rent;
 - f. Home management;
 - g. Establishing credit; and
 - h. Understanding and meeting the obligations of tenancy as defined in the lease terms.
2. Participating in the development of the POC, incorporating elements of the housing support plan;
3. Developing an individualized housing stabilization service provider plan based upon the housing assessment that:
 - a. Includes short and long-term measurable goals for each issue;
 - b. Establishing the beneficiary's approach to meeting the goal(s); and
 - c. Identifying where other provider(s) or services may be required to meet the goal(s).
4. Providing supports and interventions according to the individualized housing support plan. If additional supports or services are identified as needed outside the scope of housing stabilization service, the needs must be communicated to the support coordinator;

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5. Providing ongoing communication with the landlord or property manager regarding:
 - a. Beneficiary’s disability;
 - b. Accommodations needed; and
 - c. Components of emergency procedures involving the landlord or property manager.
6. Updating the housing support plan annually or as needed due to changes in the beneficiary’s situation or status; and
7. Providing supports to retain housing or locate and secure housing if at any time the beneficiary’s housing is placed at risk (e.g., eviction, loss of roommate or income).

Standards

Housing stabilization transition services or housing stabilization services may be provided by PSH agencies that are enrolled in Medicaid to provide these services, comply with LDH rules and regulations and are listed as a provider of choice on the FOC form.

Service Exclusions

Housing stabilization transition services or housing stabilization services are only available upon referral from the support coordinator and are not duplicative of other waiver services, including support coordination. These services are only available to beneficiaries who are residing in or who are linked for the selection process of a state of Louisiana PSH unit.

Service Limitations

No more than 165 units of combined housing stabilization transition services and housing stabilization services can be used per POC without written approval from the OCDD state office.

Reimbursement

Housing stabilization transition service and housing stabilization service are reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary.

Payment will not be authorized until the final POC approval is received.

The LGE reviews all documents to ensure all requirements are met. If all requirements are met,

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the support coordinator provides a copy of the approved POC to the beneficiary and the PSH provider. The PSH provider is notified of the release of the PA and can bill the Medicaid FI for services provided.

Services must be billed in 15 minute units.

Monitored In-Home Caregiving Services

Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a beneficiary who lives in a private unlicensed residence.

The goal of this service is to provide a community based option that provides continuous care, supports, and professional oversight and is achieved by promoting a cooperative relationship between a beneficiary, a principal caregiver, the professional staff of a monitored in-home caregiver agency provider, and the beneficiary's support coordinator.

The principal caregiver is responsible for supporting the beneficiary to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. Supervision or assistance in performing ADL;
2. Supervision or assistance in performing instrumental activities of daily living (IADL);
3. Protective supervision provided solely to assure the health and welfare of a beneficiary;
4. Supervision or assistance with health related tasks, meaning any health related procedures governed under the Nurse Practice Act, in accordance with applicable laws governing the delegation of medical tasks/medication administration;
5. Supervision or assistance while escorting/accompanying the individual outside of the home to perform tasks, including IADL, health maintenance, or other needs as identified in the POC, and to provide the same supervision or assistance as would be rendered in the home; and
6. Extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or RN.

Service Exclusions and Restrictions

Beneficiaries electing MIHC are not eligible to receive the following NOW services during the

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period of time that the beneficiary is receiving MIHC services:

1. IFS;
2. CBR;
3. SIL;
4. Adult companion care; or
5. Skilled nursing care.

MIHC providers must be agency providers who employ professional nursing staff, including a RN and a care manager, and other professionals to train and support principal caregivers to perform the direct care activities performed in the home.

The agency provider must:

1. Assess and approve the home in which services will be provided, and enter into contractual agreements with caregivers whom that agency has approved and trained;
2. Capture daily notes electronically and use the information collected to monitor beneficiary health and caregiver performance;
3. Take such notes available to support coordinators and the state, upon request;
4. Secure, web-based information collection from principal caregivers for the purposes of monitoring beneficiary health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws; and
5. Sign, maintain on file, and comply with the LDH Health Insurance Portability and Accountability Act (HIPAA) business associate addendum.

The agency provider will pay per diem stipends to caregivers. The per diem for MIHC services does not include payments for room and board. The Department shall reimburse for MIHC services based on a 2-tiered model which is designed to address the beneficiary's acuity. Reimbursement will not be made for room and board of the principal caregiver, and federal financial participation is not available for room and board.

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LDH will reimburse for MIHC based on a 2 tiered model which is designed to address the beneficiary's acuity. The following service limits apply:

1. MIHC providers shall not bill and/or receive payment on days that the beneficiary is attending or admitted to a program or setting (e.g., hospitals, nursing facilities, etc.) which provides ADL or (IADL) assistance; and
2. Provision of MIHC services outside of the borders of the state (e.g., overnight excursions, vacations, etc.) is prohibited without prior written approval by OCDD of its designee.

Provider Qualifications

MIHC providers must:

1. Be licensed according to the HCBS provider licensing requirements contained in the La. R.S. 40:2120.2-2121.9 and their implementing regulations;
2. Enroll as a Medicaid MIHC provider; and
3. Comply with LDH rules and regulations.

The principal caregiver must:

1. Be at least 18 years of age;
2. Live in the home with the beneficiary; and
3. Be available 24 hours a day, 7 days a week.

The assessment performed by the MIHC provider shall be reimbursed when the service has been approved by the POC.

Expanded Dental Services for Adult Waiver Beneficiaries

Please refer to the Dental Benefit Program Manager Manual:

https://ldh.la.gov/assets/medicaid/DBPMP/DBPM_Manual_2022-04-01.pdf

Financial Management Services

Financial management services (FMS) are provided by a Medicaid enrolled fiscal employer agent (F/EA). The F/EA is the fiscal agent that assures financial accountability for self-direction services.

FMS assist a beneficiary or an authorized representative that has been identified as able to self-direct their waiver services live independently in the community promote personal choice and control over the delivery of waiver and State Plan services, including who provides the services and how services are provided. FMS must be included and prior authorized in the approved POC prior to participation in self-direction.

Refer to the Chapter 3: F/EA Manual for additional information at:

<https://www.lamedicaid.com/provweb1/providermanuals/manuals/FEA/FEA.pdf>

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SELF-DIRECTION OPTION

Self-direction is a voluntary service delivery option the Now Opportunities Waiver (NOW) that allows the beneficiary (or their authorized representative) to become the employer of the direct service workers (DSWs) they choose to hire to provide their supports. As the employer, the beneficiary or their authorized representative is responsible for recruiting, training, supervising and managing their DSWs.

A required component of the self-direction option is the use of a fiscal/employer agent (F/EA) to perform the beneficiary's employer-related financial management services (FMS). Beneficiaries must utilize support coordination services for the development of the plan of care (POC), budget planning, ongoing evaluation of supports and services and for organizing the unique resources the beneficiary needs.

Refer to the [Fiscal/Employer Agent \(F/EA\) Manual](#) for additional information.

Beneficiaries participating in the self-direction option must:

1. Be a NOW beneficiary;
2. Be able to participate in this option without a lapse or decline in quality of care or an increased risk to their health and welfare;
3. Complete the mandatory training including rights and responsibilities of managing their own services and supports offered by the support coordinator;
4. Understand the rights, risks, and responsibilities of managing their own care, and managing and using an individual budget, or if unable to make decisions independently, have a willing decision maker (authorized representative who is listed on the beneficiary's POC) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within the individualized budget; and
5. Participation in the development and management of the approved personal purchasing plan:
 - a. Annual budget is determined by the recommended service hours listed in the beneficiary's comprehensive plan of care (CPOC) to meet their needs; and

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- b. Beneficiary’s individual budget includes a potential amount of dollars within which the beneficiary or their authorized representative exercises decision-making responsibility concerning the selection of services and service providers.

- 6. Follow all rules and requirements pertaining to self-direction as outlined in the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD) Self-Direction Option Employer Handbook.

NOTE: An individual who is unable to make decisions independently or who does not have an authorized representative as their willing decision maker is not eligible to enroll in the self-direction option. Supported living services are not allowed at the same time as the beneficiary receives the self-direction option.

Termination of the Self-Direction Service Delivery Option

Termination of participation in the self-direction service delivery option requires a revision of the CPOC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

Voluntary Termination

The waiver beneficiary may choose at any time to withdraw from the self-direction service delivery option and return to the traditional provider agency management of services.

Involuntary Termination

The Department may terminate the self-direction service delivery option for a beneficiary and require them to receive provider-managed services under the following circumstances:

- 1. Health or welfare of the beneficiary is compromised by continued participation in the self-direction service delivery option;
- 2. Beneficiary is no longer able to direct their own care and there is no responsible representative to direct the care;
- 3. There is misuse of public funds by the beneficiary or the authorized representative; or

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SECTION 32.2: SELF-DIRECTION OPTION**PAGE(S) 3**

4. Over 3 consecutive payment cycles, the beneficiary or authorized representative:
 - a. Places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;
 - b. Fails to follow the personal purchasing plan;
 - c. Fails to provide required documentation of expenditures and related items;
or
 - d. Fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures.

5. All services rendered shall be prior approved and in accordance with the CPOC.

Service Limits

Authorized representatives, legally responsible individuals, and legal guardians may be the employers in the self-directed option but may not also be the employees.

Employers of the self-direction option must live and be a resident of Louisiana.

Legally responsible individuals may only be paid for services when the care is extraordinary care in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

Family members who are employed in the self-directed option must:

1. Meet the same standards as direct support staff that are not related to the beneficiary; and
2. Must not exceed a total of 40 hours per week/per beneficiary when employed in the self-directed option, if they reside in the home with the beneficiary.

BENEFICIARY REQUIREMENTS

To qualify for the New Opportunities Waiver (NOW), a person must be three years of age or older, offered a waiver opportunity slot and meet all of the following criteria:

1. Meet the Developmental Disability Law criteria as defined in Appendix A;
2. Have their name on the Developmental Disabilities Request for Services Registry (RFSR);
3. Meet the financial and non-financial Medicaid eligibility criteria for Medicaid services;
4. Meet the medical requirements;
5. Meet the requirements for an intermediate care facility for individuals with an intellectual disability (ICF/IID) level of care (LOC) which requires active treatment of a developmental disability under the supervision of a qualified intellectual disabilities professional;
6. Meet the health and welfare assurance requirements for home and community based services (HCBS);
7. Be a resident of Louisiana; and
8. Must be a citizen of the United States or a qualified non-citizen/qualified alien.

To remain eligible for waiver services, a beneficiary must receive one or more waiver services every 30 days.

Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Individuals who request waiver services are placed on the RFSR and are selected for an Office of Citizens with Developmental Disabilities (OCDD) waiver opportunity based on their urgency of need and earliest registry date.

Requests for waiver services must be made from the applicant or their authorized representative by contacting the applicant's local governing entity (LGE).

Once it has been determined by the LGE that the applicant meets the definition of a developmental disability as defined by the Louisiana Developmental Disability Law, the applicant's name will be placed on the RFSR and the applicant/authorized representative will be sent a letter stating the individual's name has been secured on the RFSR along with the original request (protected) date. The individual will then undergo a screening for urgency of need. Entry into an OCDD Waiver will be offered to applicants from the RFSR by urgency of need and the earliest request for services date.

Verifying Screening for Urgency of Need (SUN) and Request Date

Applicants or their authorized representatives may verify their screening for urgency of need (SUN) score and request date by calling their LGE. (See Appendix C).

Level of Care

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

The OCDD "Request for Medical Eligibility Determination" 90-L Form is the instrument used to determine if an applicant meets the level of care of an ICF/IID. The 90-L Form must be completed, signed, and dated by the individual's Louisiana licensed primary care physician (PCP). A licensed advanced nurse practitioner (NP) or licensed physician's assistant may sign the 90-L, but the supervising or collaborating physician's name and address must be listed. The 90-L Form must be submitted with the individual's initial and annual plan of care (POC) to the LGE office. The LGE is responsible for determining that the required LOC is met for each beneficiary.

The applicants/authorized representatives are ultimately responsible for obtaining the completed 90-L Form from the applicant's PCP office. This form must be obtained prior to certification for the waiver for an initial POC and no more than 180 days before the annual POC start date.

Supported Independent Living providers are responsible for assisting beneficiaries who receive their services in obtaining the completed 90-L Form from the PCP on an annual basis.

Discharge Criteria

Beneficiaries will be discharged from the waiver if any one of the following criteria is met:

1. Loss of Medicaid financial eligibility as determined by the Bureau of Health Services Financing (BHSF);

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SECTION 32.3: BENEFICIARY REQUIREMENTS**PAGE(S) 3**

2. Loss of eligibility for an ICF/IID LOC as determined by the LGE;
3. Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities;
4. Change of residence to another state with the intent to become a resident of that state;
5. Admission to an ICF/IID or nursing facility with the intent to stay and not return to waiver services. The waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The beneficiary will be discharged from the waiver on the 91st day if the beneficiary is still in the facility. Payment for waiver services will not be authorized when the beneficiary is in a facility,
6. Unable to assure the health and welfare of the beneficiary in the community through the provision of reasonable amounts of waiver services as determined by the LGE, or OCDD Central Office, i.e., the beneficiary presents a danger to themselves or others;
7. Failure to cooperate in either the eligibility determination process or the initial or annual implementation of the POC, or fulfilling their responsibilities as a NOW beneficiary; or
8. Interruption of services as a result of the beneficiary not receiving and/or refusing NOW services (exclusive of support coordination services) for a period of 30 or more consecutive days. This does not include interruptions in NOW services because of hospitalization, institutionalization (such as ICF/IID or nursing facilities) or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. This interruption cannot exceed 90 days and there is a documented expectation from the treating physician that the individual will return to the NOW services. During this 90-day period, OCDD will not authorize payment for NOW services.

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

RIGHTS AND RESPONSIBILITIES

Beneficiaries of New Opportunities Waiver (NOW) services are entitled to the specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs and those contained in the Louisiana Developmental Disability Law of 2005 (Louisiana R.S. 28:452.1).

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

Freedom of Choice of Program

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

Notification of Changes

The Louisiana Department of Health (LDH) - Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the NOW program. In order to maintain eligibility, beneficiaries have the responsibility to inform BHSF of changes in their income, address, and living situation.

The LDH - Office for Citizens with Developmental Disabilities (OCDD) through the local governing entities (LGE) is responsible for approving LOC and medical certification per the Plan of Care (POC). In order to maintain this certification, beneficiaries have the responsibility to inform OCDD through their support coordinator of any significant changes which will affect their service needs.

Participation in Care

The person centered planning process will be utilized in identifying all services and supports needed to address the unmet needs of the individual. Beneficiaries/authorized representatives have the responsibility to guide the discussion with assistance from the support coordinator and service providers. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services.

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SECTION 32.4: RIGHTS AND RESPONSIBILITIES**PAGE(S) 4**

Support coordinators and service providers shall allow beneficiaries/authorized representatives to participate in all person-centered planning meetings and any other meeting concerning their services and supports. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary's needs.

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

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

Freedom of Choice of Support Coordination and Service Providers

Support coordinators should be aware that at the time of admission to the waiver and every 6 months thereafter, beneficiaries have the opportunity to change support coordination providers, if one is available. Beneficiaries may request a change by contacting the LGE.

Support coordinators will provide beneficiaries with their choice of direct service providers (DSPs) and help arrange for the services included in the POC. Beneficiaries have the opportunity to choose service providers initially and once every service authorization quarter (3 months) unless a change is requested for good cause.

Voluntary Participation

Providers must assure that the beneficiary'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 beneficiary's needs and outcomes. Beneficiaries 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 beneficiary will not be required to receive services that they may be eligible for but do not wish to receive. The intent of the NOW program is to provide community-based services to individuals who would otherwise require institutionalization.

Compliance with Civil Rights

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

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SECTION 32.4: RIGHTS AND RESPONSIBILITIES**PAGE(S) 4****Quality of Care**

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

Additional Rights

Participants have the right to control their personal resources, engage in community life, and receive services in the community to the same degree of access as individuals not receiving home and community based services. Individuals have choice regarding services and supports, and who provides them. Additional rights include the following:

1. Freedom and support to control their own schedules and activities;
2. Access to food at any time, unless contraindicated due to health and safety and documented in the POC;
3. Freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
4. Visitors of their choosing at any time;
5. Setting must be physically accessible to the individual; and
6. Control of personal resources, including wages earned in prevocational services or supported employment services.

Grievances/Fair Hearings

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

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

Rights and Responsibilities Form

A complete list of the beneficiary’s rights and responsibilities is included in Appendix D. The support coordinator must review these rights and responsibilities with the beneficiary and their authorized representative as part of the initial intake process into waiver services, and annually thereafter.

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SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for an additional Office for Citizens with Developmental Disabilities (OCDD) waiver opportunity or an existing opportunity is vacated and funded, the next individual on the Developmental Disability Request for Services Registry (DDRFSR) with the highest urgency of need screening score will receive a written notice indicating that a waiver opportunity is available. That individual will receive a needs based assessment and participate in a person centered planning process. At the conclusion of that process, if it is determined that the New Opportunities Waiver (NOW) is the most appropriate waiver for this individual, a NOW offer will be extended.

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

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

Once it has been determined that another OCDD waiver will not meet the needs of the applicant, and the NOW is the most appropriate waiver, another home visit is made to finalize the plan of care (POC). The following must be addressed in the POC:

1. The applicant's assessed needs;
2. Types and quantity of services (including waiver and all other services) necessary to maintain the applicant safely in the community;
3. Individual cost of each waiver service; and
4. Total cost of waiver services covered by the POC.

Provider Selection

The support coordinator must present the beneficiary with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the POC. The support coordinator

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will have the beneficiary or responsible representative complete the provider FOC form initially and annually thereafter for each identified waiver service.

Initial Plan of Care

The support coordinator will take the following actions:

1. Notify the provider that the beneficiary has selected their agency to provide the necessary service;
2. Schedule a meeting with the provider and the beneficiary to discuss services needed by the beneficiary;
3. After the meeting, forward a copy of the draft POC to the provider and request the provider sign and return the following:
 - a. Budget pages; and
 - b. Required POC provider attachments (e.g. Attachments B through I) as indicated in the POC.
4. Forward the initial POC packet, including provider attachments to the local governing authority or district (LGE) for review and approval.

Annual Plan of Care

Annual POCs follow the same process as an initial POC except for the following:

1. Support Coordinator supervisors are allowed to approve an annual POC based on OCDD policy; and
2. A copy of any POC approved by the Support Coordinator supervisor will be forwarded to the LGE.

NOTE: NOW services cannot begin prior to the Human Services Authority/District or Support Coordinator supervisor approval of the POC.

Prior Authorization

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All services in the NOW program must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid beneficiary by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and 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, compliance with all policy and rules for the covered services, the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service. PAs are issued in quarterly intervals directly to the provider, with the last quarterly authorization ending on the POC end date.

PA revolves around the POC document, which means that only the service codes and units specified in the approved POC will be prior authorized. Services provided without a current PA are not eligible for reimbursement.

The service provider is responsible for the following activities:

1. Checking PAs to verify that all PAs for services match the approved services in the beneficiary's POC. Any mistakes must be immediately corrected to match the approved services in the POC;
2. Verifying that the direct service worker's (DSW's) timesheet or electronic clock in/out is completed correctly and that services were delivered according to the beneficiary's approved POC prior to billing for the service;
3. Verifying that services were documented and provided as evidenced by timesheets or electronic clock in/out and progress notes and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;
4. Verifying service data in the direct service provider, Electronic Visit Verification (EVV) system or the Louisiana Services Reporting System (LaSRS) depending on the service and modifying the data, if needed, based on actual service delivery;
5. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system:
 - a. It is the provider's responsibility to ensure that billing information for the dates of service, procedure codes, and number of units delivered is correct

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and matches the information in LaSRS. Inconsistencies between LaSRS and the provider's billing system may result in recoupment.

6. Billing only for the services that were delivered to the beneficiary and are approved in the beneficiary's POC;
7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary (FI) with each payment; and
8. Checking billing records to ensure that the appropriate payment was received.

(**Note:** Service providers have a one-year timely filing billing requirement under Medicaid regulations).

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

NOTE: Authorization for services will not be issued retroactively unless approved due to special circumstances by the OCDD Waiver Director/designee.

Post Authorization

To receive post authorization, a service provider must ensure that service delivery information is reported accurately in the post authorization system maintained by the Medicaid data contractor. The Medicaid data contractor checks the service delivery information located in the post authorization system against the prior authorized units of service. Once post authorization is granted, and billing is correctly submitted by the service provider, reimbursement for the appropriate units of service will occur.

Providers of NOW services must ensure that the service provided, quantity of services, and dates of service billed align with actual delivery of services. Span date billing for services is acceptable as long as the dates align with the services being billed. Services billed and paid in excess of the services provided **on a specific date** will be recouped.

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

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PAGE(S) 11**Individual and Family Support Supplemental Payment for Complex Needs**

The provider agency is responsible for completing the OCDD Behavioral and Non-Complex Tasks Review screening tool which is required to determine if the individual requires additional support in order for the provider to receive the supplemental payment. In addition, the provider must obtain all required documentation per the screening tool in addition to preparing and submitting the required provider documents.

The Support coordination agency will submit the screening tool and the provider documents to the LGE for review and approval. Initially approval will be required from the OCDD Central Office. However, this approval may be re-directed to the Human Services Districts and Authorities in the future.

One Time Transitional Expenses

The support coordinator must develop a plan to include the transition expenses for individuals who are moving from an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institution into their own residence in the community. No funds will be disbursed without PA of expenditures. The following procedure must be followed to access these funds:

1. The support coordinator must complete the “Transitional Expenses Planning and Approval (TEPA) Request Form,” with input from the beneficiary and their circle of support, to document the need for transitional expenses, identify the designated purchaser, and estimate the cost of the items or services that are needed. The beneficiary may choose to be the designated purchaser or may select their authorized representative, support coordinator, or provider to act as the designated purchaser. (See Appendix D for a link to this form);
2. The support coordinator must request pre-approval from the LGE by submitting the TEPA request form and the POC packet, including the POC budget sheet identifying the estimated TEPA cost, procedure code, provider and provider number, at least 10 working days prior to the beneficiary’s actual move date;
3. The LGE sends the completed pre-142 approval letter and pre-approved TEPA request form to the support coordinator and OCDD Central Office Fiscal Section. A copy of the pre-142 approval letter will also be sent to the Medicaid parish office. The purchasing process cannot begin until the pre-142 approval letter is issued to the support coordinator;

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4. The support coordinator assists the designated purchaser with obtaining the items on the pre-approved TEPA request form. The beneficiary must be provided choice in the items being purchased on their behalf;
5. After purchases are made, the support coordinator is responsible for:
 - a. Obtaining the original receipts from the designated purchaser;
 - b. Identifying the pre-approved items to be reimbursed;
 - c. Notating the actual cost of the pre-approved items on the TEPA request form;
 - d. Summarizing all items purchased by the designated purchaser on the “NOW TEPA Invoice Form;”
 - e. Completing the “Request for Taxpayer Identification Number and Certification” (W-9 form) if the designated purchaser is not established as a state vendor; and
 - f. Informing the designated purchaser of the timeframes and procedures to be followed in order to obtain reimbursement.
6. The support coordinator must submit the pre-approved TEPA request form, original receipts, W-9 form (if applicable), and the TEPA Invoice form to the LGE within 90 calendar days following the pre-certification home visit;
7. The LGE reviews the purchased items with the beneficiary/authorized representative at the pre-certification home visit for approval;
8. The LGE mails the 18-W form, original receipts, pre-approved TEPA request form, and NOW TEPA Invoice Form to the OCDD Central Office Fiscal Section upon receipt. Payment will not be authorized until the LGE gives final POC approval upon receipt of the 18-W form;
9. The OCDD Central Office Fiscal Section establishes a transition expense record for the beneficiary and utilizes the pre-approved TEPA request form to ensure that only the item/services listed are reimbursed to the designated purchaser;
10. The support coordinator must submit a revised POC budget sheet to the LGE if there are any cost differences between the approved estimated TEPA cost and the

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actual TEPA cost;

11. The OCDD Central Office Fiscal Section sends the “OCDD Verification of Actual TEPA Costs” form to the LGE for service authorization;
12. The LGE gives final approval on the “OCDD Verification of Actual TEPA Costs” form and faxes it to the Medicaid data contractor along with the approved TEPA request form and accompanying POC budget sheets. A copy of the “OCDD Verification of Actual TEPA Costs” form is faxed back to the OCDD Central Office Fiscal Section for documentation in the OCDD payment record;
13. Service authorization is issued to the OCDD Central Office Fiscal Section for the actual cost of items as identified on the approved TEPA request form. Any new items not on the original approved TEPA Request Form will not be reimbursed; and
14. The OCDD Central Office forwards the reimbursements to the designated purchaser upon payment from Medicaid.

All billing must be completed by the POC end date in order for the reimbursement to be paid. OCDD central office Fiscal Section maintains documentation for accounting and monitoring purposes of each beneficiary’s TEPA request including original receipts and record of payments to the designated purchaser

Additional requests for one time transitional expenses must be requested by the beneficiary and submitted by the support coordinator on a new TEPA request form to the LGE following the above procedure. Requests must be approved 60 calendar days prior to the expiration of the original POC.

Changes

All requests for changes in services and/or service hours must be made by the beneficiary or their personal representative.

Changing Direct Service Providers

Beneficiaries may change direct service providers once every service authorization quarter (three months) with the effective date being the beginning of the following quarter. Direct service providers (DSPs) may be changed for good cause at any time as approved by the LGE.

Good cause is defined as:

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1. Beneficiary moving to another region in the state where the current DSP does not provide services;
2. Beneficiary and the DSP have unresolved difficulties and mutually agree to a transfer;
3. Beneficiary would like to share supports with another beneficiary who has a different provider agency, regardless of the beneficiary's relationship;
4. Beneficiary's health, safety or welfare have been compromised; or
5. DSP has not rendered services in a manner satisfactory to the beneficiary or their authorized representative.

Beneficiaries and/or their authorized representative must contact their support coordinator to change DSPs.

The support coordinator will assist in facilitating a support team meeting to address the beneficiary's reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider should have the opportunity to submit a corrective action plan with specific timelines, not to exceed 30 calendar days, to attempt to meet the needs of the beneficiary.

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

1. Provide the beneficiary/ authorized representative with a current FOC list of service providers in their region;
2. Assist the beneficiary/authorized representative in completing the FOC list and release of information form;
3. Ensure the current provider agency is notified immediately upon knowledge and prior to the transfer; and
4. Obtain the case record from the releasing provider which must include:
 - a. Progress notes from the last 2 months, or if the beneficiary has received

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- services from the provider for less than 2 months, all progress notes from date of admission;
- b. Written documentation of services provided, including monthly and quarterly progress summaries;
 - c. Current POC provider documents;
 - d. Records tracking beneficiary's progress towards POC goals and objectives, including standardized vocational assessments and/or notes regarding community or facility-based work assessments, if applicable;
 - e. Records of job assessment, discovery, and development activities which occurred, and a stated goal and objective in the most current Individualized Service Plan (ISP) for the beneficiary to obtain competitive work in the community, if stated;
 - f. Copies of current and past behavior management plans, if applicable;
 - g. Documentation of the amount of authorized services remaining in the POC, including applicable time sheets; and
 - h. Documentation of exit interview.

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

- 1. Most current POC;
- 2. Current assessments on which the POC is based;
- 3. Number of services used in the PA periods for the current POC year;
- 4. Records from the previous service provider; and;
- 5. All other waiver documents necessary for the new service provider to begin providing service.

Transfers must be made 7 calendar days prior to the end of the service authorization quarter in order to coordinate services and billing, unless the LGE waives this requirement in writing due to good cause.

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The new service provider must bear the cost of copying, which cannot exceed the community’s competitive copying rate. If the existing provider charges a rate that exceeds the competitive copying rate, then the provider should contact the support coordinator to resolve the issue.

Prior Authorization for New Service Providers

A new PA number will be issued to the new provider with an effective starting date of the first day of the new quarter or the date agreed to by the new provider. The transferring agency’s PA number will expire on the date immediately preceding the PA date for the new provider. New providers who provide services prior to the start date on the new PA will not be reimbursed.

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

Changing Supported Independent Living Providers

Changes in Supported Independent Living (SIL) providers will be effective on the Sunday following the approved request to change agencies. The agency the beneficiary is leaving will be responsible for completing all required contacts in the last week. The new provider agency will be responsible for completing these requirements beginning the week the transfer is effective. In instances where there is a need for an emergency change in providers at any other day during the week, the new provider agency will be responsible for meeting the weekly requirements.

If a new beneficiary begins receiving SIL services on a day other than Sunday due to an emergency, the provider will also be required to meet all weekly requirements in order to receive payment.

Changing Support Coordination Agencies

A beneficiary may change support coordination agencies after a 6-month period or at any time for good cause if the new agency has not met its maximum number of beneficiaries. Good cause is defined as:

1. Beneficiary moving to another region in the state;
2. Beneficiary and the support coordination provider have unresolved difficulties and mutually agree to a transfer;
3. Beneficiary’s health, safety or welfare have been compromised; or

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4. Support coordination provider has not rendered services in a manner satisfactory to the beneficiary.

Participating support coordination agencies should refer to the Case Management Services manual chapter in the *Louisiana Medicaid Provider Manual* which provides a detailed description of their roles and responsibilities.

PROVIDER REQUIREMENTS

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

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

Providers must attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) or the local governing entity (LGE) 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 will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number.

Providers must participate in the initial training for prior authorization (PA) and data collection and in 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, software, and internet connectivity necessary to participate in PA, data collection, and Electronic Visit Verification (EVV).

It is the provider's responsibility to ensure that use of contractors, including independent contractors, complies with all state and federal laws, rules, and/or regulations, including those enforced by the United States Department of Labor.

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

Brochures providing information on the agency's experience must include the agency's toll-free number along with the OCDD's toll-free information number. OCDD must approve all brochures prior to use.

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Providers must develop a quality improvement and self-assessment plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first self-assessment is due 6 months after approval of the Quality Improvement Plan (QIP) and yearly thereafter.

The QIP must be submitted for approval within 60 days after the training is provided by LDH.

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

The agency must be excluded for participation as an entity as evidenced by an open exclusion on the Louisiana State Adverse Actions database, the Office of Inspector General's (OIG) national exclusions database, or the federal System for Award Management (SAM) database. The agency must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Changes in the following areas are to be reported to the Office of the Secretary's Health Standards Section (HSS), OCDD, and the fiscal intermediary's (FI's) Provider Enrollment Section in writing at least 10 days prior to any change:

1. Ownership;
2. Physical location;
3. Mailing address;
4. Telephone number; and
5. 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 beneficiaries. 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 beneficiaries until the re-certification process is complete.

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

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Providers may not refuse to serve any waiver beneficiary who chooses their agency unless there is documentation to support an inability to meet the individual’s health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. Such refusal to serve an individual must be put in writing by the provider and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the LGE. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver beneficiary referred to the subcontractor by the enrolled direct service provider (DSP) agency.

The beneficiary’s provider and support coordination agency (SCA) must have a written working agreement that includes the following:

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

The New Opportunities Waiver (NOW) services outlined below may be provided by the provider or by an agreement with other contracted agents. The actual provider of the service, whether it is the provider or a subcontracted agent, must meet the following licensure or other qualifications:

Waiver Service	Requirements	Service Provided by
Individualized and Family Support (IFS)	Home and Community-Based Services (HCBS) Provider License (Personal Care Attendant (PCA) Module)	Enrolled agency
Center Based Respite (CBR)	HCBS Provider License (Respite Care Module)	Enrolled agency
Community Integration Development	HCBS Provider License (PCA or Supervised Independent Living Module)	Enrolled agency
Residential Habilitation – Supported Independent Living (SIL)	HCBS Provider License (Supervised Independent Living Module)	Enrolled agency

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Waiver Service	Requirements	Service Provided by
Substitute Family Care	HCBS Provider License (Substitute Family Care Module and approved by OCDD)	Enrolled agency
Day Habilitation	HCBS Provider License (Adult Day Care Module)	Enrolled agency
Monitored In-Home Caregiving (MIHC) Services	HCBS Provider License	Enrolled agency
Supported Employment	Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or 15 hours of documented initial and annual vocational-based training plus a HCBS Provider License (Supported Employment Module)	Enrolled agency
Prevocational Services	HCBS Provider License (Adult Day Health Care (ADHC) Module with notification to Health Standards that Prevocational Services will be provided)	Enrolled agency
Environmental Accessibility Adaptations (EAAs)	Registered through the Louisiana State Licensing Board for Contractors as a Home Improvement Contractor	Enrolled agency
	Vehicle Lifts: Licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category	
Specialized Medical Equipment and Supplies (SMES)	Must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies	Enrolled agency
Personal Emergency Response Systems (PERS)	Must meet all applicable vendor requirements, federal, state, parish and local laws for installation	Enrolled agency
Professional Services	Current valid Louisiana license to practice in the field of expertise	Employed or contracted by HCBS Provider (PCA Module, Supervised Independent Living Module or Home Health agency)
Skilled Nursing	Home Health license	Enrolled agency
Adult Companion Care	HCBS Provider License (PCA Module) or MIHC License	Enrolled agency

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Waiver Service	Requirements	Service Provided by
One Time Transitional Expenses		OCDD

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

Other Provider Responsibilities

Providers of NOW services are responsible for the following:

1. Ensuring an appropriate representative from the agency attends the POC planning meeting and is an active participant in the team meeting;

NOTE: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the beneficiary’s service delivery. This person may be a program manager, case supervisor, or the executive director or designee. An unlicensed direct service worker (DSW) is not considered an appropriate representative for the POC planning meeting.

2. Communicating and working with support coordinators and other support team members to achieve the beneficiary’s personal outcomes;
3. Ensuring the provider POC documents are updated as changes occur, including the beneficiary’s emergency contact information and list of medications;
4. Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or timelines in the POC will not meet the beneficiary’s needs, but not later than 10 days prior to the expiration of any timelines in the service plan that cannot be met;
5. An update to the provider documents should only occur as a result of a **documented** meeting with the beneficiary or authorized representative where the reason for change is indicated and all parties sign the meeting attendance record;
6. Ensuring the provider agency support team member(s) sign and date any revisions to the service plan indicating agreement with the changes to the goals, objectives or time lines;

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7. Providing the SCA or LDH representatives with requested written documentation including, but not limited to:
 - a. Completed, signed, and dated service plan;
 - b. Service logs, progress notes, and progress summaries;
 - c. DSW attendance and payroll records;
 - d. Written grievance or complaint filed by beneficiary/family;
 - e. Critical or other incident reports involving the beneficiary; and
 - f. Entrance and exit interview documentation.
8. Explaining to the beneficiary/family in their native language the beneficiary rights and responsibilities within the agency;
9. Assuring that beneficiaries are free to make a choice of providers without undue influence; and
10. Medicaid has established a DSW Wage floor. Provider agencies must follow these rules and pay the DSW as directed by Medicaid. The current wage floor can be found in the Louisiana Administrative Code (LAC) and the OCDD will post a memo on the OCDD website (<https://ldh.la.gov/index.cfm/subhome/11/n/8>). Providers will be responsible for following this directive.

Support Coordination Providers**Support Coordination**

Support Coordination is a service that will assist beneficiaries in gaining access to all of their needed support services, including medical, social, educational, and other services, regardless of the funding source for the services. Providers of support coordination for the NOW program must have a signed performance agreement with OCDD to provide services to waiver beneficiaries. Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined by the program office.

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Support Coordination activities include but are not limited to the following:

1. Convening the person-centered planning team comprised of the beneficiary, beneficiary's family, DSPs, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies needed in order to meet the beneficiary's needs and preferences;
2. On-going coordination and monitoring of supports and services included in the beneficiary's approved POC;
3. Building and implementing the supports and services as described in the POC;
4. Assisting the beneficiary 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 beneficiary in the POC;
5. Providing information to the beneficiary on potential community resources, including formal resources and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining their desired personal outcomes;
6. Assisting with coordinating transportation to access medical services and community resources;
7. Assisting with problem solving with the beneficiary, families, services providers, and/or LGEs;
8. Assisting the beneficiary 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;
9. Advocating on behalf of the beneficiary to assist them in obtaining benefits, supports or services, i.e. to help establish, expand, maintain and strengthen the beneficiary's information and natural support networks. This may involve calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;
10. Training and supporting the beneficiary in self-advocacy, i.e. the selection of providers and utilization of community resources to achieve and maintain their desired outcomes;

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11. Oversight of the service providers to ensure that their beneficiary receives appropriate services and outcomes as designated in the POC;
12. Assisting the beneficiary to overcome obstacles, recognize potential opportunities and developing creative opportunities;
13. Meeting with the beneficiary in a face-to-face meetings as well as telephone contact as specified. This includes meeting them where the services take place;
14. Must report and document any incidents/complaints/abuse/neglect according to the OCDD policy and in accordance with licensure, state laws, rules, and regulations, as applicable;
15. Must arrange any necessary professional/clinical evaluations needed and ensure beneficiary choice;
16. Must identify gather and review the array of formal assessments and other documents that are relevant to the beneficiary's needs, interests, strengths, preferences, and desired personal outcomes;
17. Develop an action plan in conjunction with the beneficiary to monitor and evaluate strategies to ensure continued progress toward the beneficiary's personal outcomes; and
18. On-going discussions with the beneficiary (aged 16 years or older) about employment including identifying barriers to employment and working to overcome those barriers, connecting the beneficiary to certified work incentive coordinators (CWIC) to do benefits planning, referring the beneficiary to Louisiana Rehabilitation Services (LRS) and following the case through closure with LRS, and other activities of the employment process as identified. This includes the quarterly completion of and data input using the Path to Employment Form.

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

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Support Coordination Providers Qualifications

Support Coordination providers must meet the following requirements:

1. Be licensed as a support coordination provider; and
2. Meet all requirements as outlined in the *Support Coordination Performance Agreement*.

NOTE: Please refer to the *Guidelines for Support Planning, Operational Instruction for Critical Incident Review*, and *OCDD Support Coordination Reference Guide* for additional information.

Direct Service Provider Responsibilities

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

1. Training policy that includes orientation and staff training requirements according to the HCBS Providers Licensing Standards and the DSW Registry;
2. Direct care abilities, skills, and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver beneficiaries;
3. 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;
4. Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal;
5. Identification, notification, and protection of beneficiary's rights, both verbally and in writing, in a language the beneficiary/family is able to understand;
6. Written grievance procedures;
7. Information about abuse and neglect as defined by LDH regulations and state and federal laws;

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- 8. EVV: requirements/proper use of check in/out; acceptable editing of electronically captured services; reporting services when in “no service zones” or failure to clock in/out (Electronic Connectivity Form and manual entry); confidentiality of log in information; monitoring of EVV system for proper use;

NOTE: NOW providers must use the EVV system designated by the Department for automated scheduling, time and attendance tracking, and billing for certain HCBS. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the NOW provider manual.

- 9. DSW Registry: requirement for accessing the department’s Adverse Action database for findings placed against the DSWs prohibiting employment; and
- 10. Criminal History Checks: requirement for compliance with state statutes for non-licensed direct care personnel.

POC Provider Documents

The DSP must complete the provider portion of the POC to include all waiver services that the agency provides to the beneficiary based on the identified POC goals and other supports required.

The provider documents in the POC must be person-centered, focus on the beneficiary’s desired outcomes and include the following elements:

- 1. Specific activities to achieve the goals outlined in the beneficiary’s approved POC; and
- 2. Strategies or supports needed to meet the individual’s needs.

The POC provider documents must be reviewed and updated as necessary to comply with the specified goals, objectives, and timelines stated in the beneficiary’s approved POC or when changes are necessary based on beneficiary needs.

Providers who receive the IFS supplemental payment for supporting individuals with complex behavioral needs are responsible for preparing the Behavioral Supports (comprehensive plan of care (CPOC) Attachment G) and the Emotional Wellness Crisis Prevention Plan (CPOC Attachment F). Providers who receive the IFS supplemental payment for supporting individuals with complex medical needs are responsible for completing the Complex Care Medical Supports (CPOC Attachment L) and any documentation required by Attachment L. Providers are also

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responsible for providing evidence of training by a registered nurse (RN), including written delegations for the direct care staff to perform the non-complex medical tasks. A current RN assessment is also required and is to be updated quarterly.

Back-up Planning

DSPs are responsible for providing all of the necessary staff to fulfill the health and welfare needs of the beneficiary when paid supports are scheduled to be provided. This includes times when the scheduled DSW is absent or unavailable or unable to work for any reason.

All DSPs are required to develop an individualized back-up plan for each beneficiary. DSPs are required to have policies in place which outline the protocols the agency has established to assure that back-up DSWs are readily available, lines of communication and chain of command procedures have been established, and procedures for dissemination of the back-up plan information to beneficiaries, their authorized representatives and support coordinators. Protocols must also describe how and when the direct support staff will be trained in the care needed by the beneficiary. This training must occur prior to any direct support staff being solely responsible for a beneficiary.

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

DSPs may not use the beneficiary's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements without documented consent of the informal support system. The beneficiary's family members and others identified in the beneficiary's circle of support may elect to provide backup, but this does not exempt the provider from the requirement of providing the necessary staff for backup purposes when paid supports are scheduled.

Emergency Evacuation Planning

Emergency evacuation plans must be developed in addition to the beneficiary's individualized back-up plan. Providers must have an emergency evacuation plan that specifies in detail how the DSP will respond to potential emergency situations such as fires, hurricanes, tropical storms, hazardous material release, flash flooding, ice storms, and terrorist attacks.

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

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1. Individualized risk assessment of potential health emergencies;
2. A detailed plan to address the beneficiary's individualized evacuation needs, including a review of the beneficiary's individualized back-up plan, during geographical and natural disaster emergencies and all other potential emergency conditions;
3. Policies and procedures outlining the agency's implementation of emergency evacuation plans and the coordination of these plans with the local Office of Emergency Preparedness and Homeland Security;
4. Establishment of effective lines of communication and chain of command procedures;
5. Establishment of procedures for the dissemination of the emergency evacuation plan to beneficiaries and support coordinators; and
6. Protocols outlining how and when DSWs and beneficiaries will be trained in the implementation of the emergency evacuation plan and post-emergency procedures.

Training for DSWs and verification of competency must occur prior to the worker being solely responsible for the support of the beneficiary.

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

OCDD, support coordination agencies, and DSP agencies are responsible for following the established emergency protocol before, during, and after hurricanes or other natural disasters or events as outlined in the "Emergency Protocol for Tracking Location Before, During and After Hurricanes" document found in the OCDD *Guidelines for Support Planning* manual. (See Appendix D for *Guidelines for Support Planning* information).

Residential Habilitation – Supported Independent-Living Provider Responsibilities

In addition to the approved direct support hours provided to the beneficiary, the SIL provider is responsible for maintaining weekly contact with the beneficiary for supervision purposes and making a minimum of one monthly face-to-face contact in the home to ensure the living situation complies with licensing requirements. The minimum requirements for SIL contacts are as follows:

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1. Two contacts every week (Sunday through Saturday) with the beneficiary, either face-to-face, by phone, or through adaptive communication technology. These 2 weekly contacts are for supervision purposes and are intended to provide the beneficiary an opportunity to express concern and provide assurance that all needs are being met; and
2. One monthly contact (each calendar month) face-to-face with the beneficiary in the beneficiary's home. This contact is intended to ensure that the living situation is safe, that it complies with licensing requirements, and that all necessary support is provided to the beneficiary (medications are refilled, no repairs are necessary, adequate food is in home, bills are paid, staff is working the hours required, no abuse/neglect, etc.). The frequency of the face-to-face contacts shall be based on the beneficiary's needs.

The weekly supervision contacts are separate from the monthly in-home contact; therefore, the monthly in-home contact will not count as one of the 2 weekly contacts required. Providers may make as many contacts in a day as are necessary to meet the needs of the beneficiary. However, only one contact per day (either weekly or monthly contacts) will count towards meeting the minimum contacts required. Attempted contacts are unacceptable and will not count towards meeting any of the minimum contact requirements. Any identified payment made to a provider agency for an incomplete contact will be subject to recoupment of funds paid. All contacts used for billing purposes must be documented. The contact must identify the name of the beneficiary contacted, date of the contact, beginning and ending time of the contact, topics discussed during the contact, and the printed name and signature of the person making the contact.

Beneficiary contacts must be completed by a supervisor of the provider agency so designated due to the supervisor's experience and expertise relating to client needs or an employee of the provider agency who is a licensed/certified professional (Qualified Intellectual Disability Professional) qualified in the State of Louisiana and who meets the requirements as defined by the Title 42, Section 483.430 of the Code of Federal Regulations (CFR) [42 CFR 483.430]. Providers are required to maintain appropriate documentation indicating these requirements for all required contacts.

NOTE: The billing week begins at midnight Sunday (12:00 a.m.) and ends at midnight the following Sunday (12:00 a.m.).

The provider must provide back-up staff that is available on a 24-hour basis. SIL services must be coordinated with any services listed in the approved POC.

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SIL providers are responsible for assisting beneficiaries with obtaining the completed Form 90-L from their primary care physician (PCP) on an annual basis.

Day Habilitation Provider Responsibilities

The service provider must possess a current valid HCBS Providers License to provide ADHC services and adhere to the following requirements in order to provide transportation to beneficiaries:

1. The provider's vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;
2. Providers must maintain liability insurance in the amount specified in the HCBS licensing requirements;
3. Drivers must have a current Louisiana driver's license applicable to the vehicle being used; and
4. The provider must document this service in the provider's transportation log, which can be either electronic with Global Positioning System (GPS) tracking or a paper log. The log is not required to be filed in the beneficiary's record file, but must contain information that identifies the beneficiary, the time of pick up, and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGEs and Support Coordination.

Supported Employment Provider Responsibilities

Supported Employment providers must maintain documentation in the file of each individual beneficiary that the services are not available to the beneficiary in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) [20 U.S.C. 1401 (26) and (29)].

The service provider must possess a current valid HCBS Providers License provide ADHC services to provide ADHC services and adhere to the following requirements in order to provide transportation to beneficiaries:

1. The provider's vehicles used in transporting beneficiaries must adhere to the requirements of the HCBS licensing rule;

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2. Drivers must have a current Louisiana driver's license applicable to the vehicle being used; and
3. The provider must document this service in the provider's transportation log, which can be either electronic with GPS tracking or a paper log. The log is not required to be filed in the beneficiary's record file, but must contain information that identifies the beneficiary, the time of pick up and the time of drop off. It shall also be available upon request for review by any Louisiana state agency, including LGEs and Support Coordination.

Prevocational Services Provider Responsibilities

The provider must maintain documentation in the file of each individual beneficiary receiving Prevocational Services that the services are not available to eligible beneficiaries in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the IDEA [20 U.S.C. 1401 (26) and (29)].

Professional Services – Psychological Provider Responsibilities

Providers of psychological services must:

1. Perform an initial evaluation to assess the beneficiary's need for services;
2. Develop an Individualized Service Plan (ISP) for the provision of psychological services, which must document the supports that will be provided to the beneficiary to meet their goals based on the beneficiary's approved POC;
3. Implement the beneficiary's therapy service plan in accordance with appropriate licensing and certification standards;
4. Complete progress notes for each session, within 10 calendar days of the session, and provide notes to the beneficiary's support coordinator every 3 months or as specified in the POC;
5. Maintain both current and past records and make them available upon request to OCDD, service providers, support coordinators, CMS, and/or legislative auditors; and
6. Bill only for services rendered, based on the beneficiary's approved POC and PA.

Skilled Nursing Services Provider Responsibilities

Provider agencies of skilled nursing services must:

1. Ensure that all nurses employed to provide skilled nursing services are either RNs or licensed practical nurses (LPNs) who have a current Louisiana Board of Nursing license with a minimum of one year of supervised nursing experience in providing Skilled nursing services in a community setting to beneficiaries;
2. Provide an orientation on waiver services to licensed nurses and assure that licensed nurses adhere to the OCDD Critical Incident Reporting policy. (See Appendix D for information regarding this policy);
3. Collect and submit the following documents to the beneficiary's SCA:
 - a. PCP's order for Skilled Nursing services:
 - i. The physician's order must be signed and dated and must contain the number of hours per day and duration of Skilled Nursing services required to meet the beneficiary's needs. This order must be updated at least every 60 days. The physician's order must be submitted to the LGEs with the beneficiary's annual POC and upon request. PA will not be released if the physician's order is not submitted as required.
 - b. PCP's letter of necessity for Skilled Nursing services:
 - i. The physician's letter of medical necessity must be on the physician's letterhead.
 - c. Current Form 90-L signed by the beneficiary's PCP;
 - d. Summary of the beneficiary's medical history:
 - i. The summary must indicate the beneficiary's service needs, based on a documented record review, and specify any recent (within one year) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) extended home health service approvals.

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- e. CMS Form 485 completed by the home health agency to identify the Skilled Nursing service needs.
4. Develop and implement an Individual Nursing Service Plan in conjunction with the beneficiary's physician, support team, and the support coordinator to identify and fulfill the beneficiary's specific needs in a cost-effective manner;
5. Render services to the beneficiary as ordered by the beneficiary's PCP and as reflected in the beneficiary's POC within the requirements of the Louisiana Nurse Practice Act. For the purpose of this policy, nursing assessments, nursing care planning, and revisions of care planning must be consistent with the Outcome and Assessment Information Set (OASIS) requirements used by home health agencies that provide Skilled Nursing services;
6. Complete progress notes for each treatment, assessment, intervention, and critical incident;
7. Provide the SCA with physician-ordered changes every 60 days regarding the beneficiary's health status and health needs;
8. Inform the support coordinator immediately of the providers' inability to provide staff according to the beneficiary's nursing service plan;
9. Report any beneficiary's non-compliance with or refusal of the established Individual Nursing Service Plan and provide these notes to the designated support coordinator every 3 months, or as specified in the POC;
10. Maintain both current and past records and make them available upon request to the OCDD, service providers, support coordinators, CMS, and/or legislative auditors;
11. Bill for prior authorized services rendered based on the beneficiary's approved POC;
12. Ensure the home health nurse and the beneficiary's support coordinator communicate at least monthly to determine if any further planning is required;
13. Report any changes in the beneficiary's nursing service needs to the support coordinator. If necessary, the support coordinator will call an interdisciplinary team (IDT) meeting to review the POC and to discuss any needed revisions. Changes to

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skilled nursing services, in accordance with regulations, must be reflected in the Individual Nursing Services Plan and submitted to the support coordinator every 60 days;

NOTE: It is not necessary to revise the POC every 60 days unless there is a change in the beneficiary's medical condition requiring the need for additional Skilled Nursing services or the beneficiary requests a change.

14. Changes in the Individual Nursing Service Plan must be approved by the PCP and reflect the physician's orders for the skilled nursing service;
15. Ensure the Individual Nursing Service Plan is current and available in the beneficiary's home at all times;
16. Follow all NOW requirements, minimum standards for home health agencies and state and federal rules and regulations for licensed home health agencies and nursing care; and
17. Comply with OCDD standards for payment, Medical Assistance Program Integrity Law (MAPIL), Health Insurance Portability and Accountability Act (HIPAA), Americans with Disabilities Act (ADA), and licensing requirements.

Adult Companion Care Services Provider Responsibilities

The provider organization must develop a written agreement as part of the beneficiary's POC that defines all of the shared responsibilities between the companion and the beneficiary. The written agreement shall include, but is not limited to the following:

1. Types of support provided by the companion;
2. Activities provided by the companion; and
3. A typical weekly schedule.

Revisions to this agreement must be facilitated by the provider organization and approved by the support team. Revisions may occur at the request of the beneficiary, the companion, the provider, or other support team members.

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The provider organization is responsible for performing the following functions which are included in the daily rate:

1. Arranging the delivery of services and providing emergency services;
2. Making an initial home visit to the beneficiary's home, as well as periodic home visits as required by the department;
3. Contacting the companion a minimum of once per week or as specified in the beneficiary's comprehensive POC;
4. Providing 24-hour oversight and supervision of the adult companion care services, including back-up for the scheduled and unscheduled absences of the companion; and
5. Facilitating a signed written agreement between the companion and the beneficiary that assures the following:
 - a. The companion's portion of expenses must be at least \$200 per month, but shall not exceed 50 percent of the combined monthly costs, which include rent, utilities, and primary telephone expenses; and
 - b. Inclusion of any other expenses must be negotiated between the beneficiary and the companion. These negotiations must be facilitated by the provider, and the resulting agreement must be included in the written agreement and in the beneficiary's POC.

STAFFING REQUIREMENTS

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

Individualized and Family Support

1. Family members who provide individualized and family support (IFS) services must meet the same standards as providers or direct care staff who are unrelated to the beneficiary. Service hours for family members living in the home will be capped at 40 hours per week, Sunday to Saturday;
2. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide IFS services for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary;
3. Family members who provide IFS services must meet the same standards as providers or direct care staff who are unrelated to the individual;
4. Services are not allowed to be provided in the direct service worker's (DSW's) place of residence;
5. IFS services shall be provided in the state of Louisiana. IFS services may be performed outside the state for a time-limited period or for emergencies. The provision of services outside of the state must be prior-approved by the Department;
6. Provision of IFS services shall not be authorized outside of the United States or the Territories of the United States; and
7. The provision of IFS services in licensed congregated settings shall be excluded from coverage.

Residential Habilitation – Supported Independent Living

Supported independent living (SIL) shall not include the cost of:

1. Meals or the supplies needed for preparation;
2. Room and board;
3. Home maintenance, or upkeep, improvement, modifications, or adaption to a home, or to meet the requirements of the applicable life safety code;
4. Routine care and supervision which could be expected to be provided by a family member; or
5. Activities or supervision for which a payment is made by a source other than Medicaid, e.g., Office for Citizens with Developmental Disabilities (OCDD), etc.

SIL services cannot be provided in a substitute family care setting.

Beneficiaries receiving adult companion care services are not eligible to receive SIL services.

Monitored in-home-caregiving (MIHC) services are not eligible to be provided at the same time or on the same day as SIL.

Service Limit

SIL services are limited to one service per day, per comprehensive plan of care (CPOC) year, except when the beneficiary is in center-based respite (CBR). When a beneficiary living in an SIL setting is admitted to a CBR facility, the SIL provider shall not bill the SIL per diem beginning with the date of admission to the CBR facility and through the date of discharge from the CBR facility.

Substitute Family Care

Immediate family members, such as a beneficiary’s mother, father, brother, sister, spouse, or curator, cannot be Substitute Family Care parents.

Adult Companion Care

Companions must meet the DSW requirements as provided by LDH Licensing. The individual and the companion live in the same household.

The companion is a principal care provider chosen by the beneficiary, who provides services in the beneficiary's home and lives with the beneficiary as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the beneficiary's POC.

The companion shall be available in accordance with a pre-arranged time schedule and available by telephone for crisis support on short notice.

The companion is responsible for participating in, and abiding by, the plan of care (POC), maintaining records in accordance with state and provider requirements, and purchasing their own food and personal care items.

Monitored In-Home Caregiving

The principal caregiver is responsible for supporting the beneficiary to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. Supervision or assistance in performing activities of daily living (ADL);
2. Supervision or assistance in performing instrumental ADL;
3. Protective supervision provided solely to assure the health and welfare of a beneficiary;
4. Supervision or assistance with health related tasks, meaning any health related procedures governed under the Nurse Practice Act, in accordance with applicable laws governing the delegation of medical tasks/medication administration;
5. Supervision or assistance while escorting/accompanying the individual outside of the home to perform tasks, including instrumental activities of daily living (IADL), health maintenance, or other needs as identified in the POC, and to provide the same supervision or assistance as would be rendered in the home;
6. Extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse (RN); and

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SECTION 32.7: STAFFING REQUIREMENTS

7. Beneficiaries electing MIHC are not eligible to receive the following NOW services during the period of time that the beneficiary is receiving MIHC services:
 - a. IFS;
 - b. CBR;
 - c. SIL;
 - d. Adult companion care; or
 - e. Skilled nursing care.

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 (LDH) administrative region where the beneficiary resides. The agency must have sufficient space, facilities, and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the beneficiary served and the provision of services.

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

Confidentiality and Protection of Records

All records, including but not limited to administrative and beneficiary files, must be secured against loss, tampering, destruction, or unauthorized use. Providers must comply with all laws and regulations concerning confidentiality which safeguard information and patient/client confidentiality.

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

1. Court order;
2. Beneficiary's written informed consent for release of information;
3. Written consent of the individual to whom the beneficiary's rights have been devolved when the beneficiary has been declared legally incompetent; or
4. Written consent of the parent or legal guardian when the beneficiary is a minor.

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A provider must, upon request, make available information in the case records to the beneficiary or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the beneficiary, or reasonably likely to endanger the life or physical safety of the beneficiary, that information may be withheld. This determination must be documented in writing.

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

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

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

Review by State and Federal Agencies

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

Retention of Records

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

1. 6 years from the date of the last payment period; or
2. Until records are audited and all audit questions are resolved.

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

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Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, LDH administrative rules and Medicaid enrollment agreements.

Beneficiary Records

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

All beneficiary records and location of documents contained therein must be maintained consistently in the agency. Records must be appropriately maintained so that current material can be located in the record.

The Office of Citizens with Developmental Disabilities (OCDD) does not prescribe a specific format for documentation, but all components outlined below must be in each beneficiary's active record.

Organization of Records, Record Entries and Corrections

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

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

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

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

Components of Beneficiary Records

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

1. Identifying information on the beneficiary that is recorded on a standardized form to include the following:
 - a. Name;
 - b. Home address;
 - c. Home telephone number;
 - d. Date of birth (DOB);
 - e. Sex;
 - f. List of current medications;
 - g. Primary disability;
 - h. Name and phone number of preferred hospital;
 - i. Closest living relative;
 - j. Marital status;
 - k. Name and address of current employment, school, or day program, as appropriate;
 - l. Date of initial contact;
 - m. Court and/or legal status, including relevant legal documents, if applicable;
 - n. Names, addresses, and phone numbers of other beneficiaries or providers involved with the beneficiary's plan of care (POC) including the beneficiary's primary or attending physician;
 - o. Date this information was gathered; and
 - p. Signature of the staff member gathering the information.

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2. Documentation of the need for ongoing services;
3. Medicaid eligibility information;
4. A copy of assurances of freedom of choice (FOC) of providers, beneficiary rights and responsibilities, confidentiality, and grievance procedures, etc. signed or initialed by the beneficiary;
5. Approved POC and provider documents, including any revisions;
6. Copy of all critical incident reports, if applicable;
7. Formal grievances filed by the beneficiary;
8. Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified in the Service Documentation below;
9. Attendance records;
10. Copy of the beneficiary’s behavior support plan, if applicable;
11. Documentation of all interventions (medical, consultative, environmental and adaptive) used to ensure the beneficiary’s health, safety, and welfare;
12. Reason for case closure and any agreements with the beneficiary at closure;
13. Copies of all pertinent correspondence;
14. At least 6 months (or all information if services provided less than 6 months) of current pertinent information relating to services provided;

NOTE: Records older than 6 months may be kept in storage files or folders, but must be available for review.

15. Any threatening medical condition including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or any known allergies;

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16. Monitoring reports of waiver service providers to ensure that the services outlined in the POC are delivered as specified;
17. Service logs describing all contacts, services delivered and/or action taken identifying the beneficiaries involved in service delivery, the date and place of service, the content of service delivery and the services relation to the POC;
18. A sign-out sheet that indicates the date and signature of the person(s) who viewed the record; and
19. Any other pertinent documents.

The provider must ensure that drivers have access to needed medical information including emergency contacts in the event of an emergency for all beneficiaries they transport. If this information is kept as a hard copy record in the vehicle, it must be returned to a secure location at the provider agency at the end of the transportation service.

Service Documentation

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

Required service documentation includes:

1. Service logs;
2. Progress notes;
3. Progress summaries;
4. Discharge summaries for transfers and closures; and
5. Individualized documentation.

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

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Service Logs

A service log provides a chronological listing of contacts and services provided to a beneficiary. They reflect the service delivered and document the services billed.

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

1. Name of beneficiary;
2. Signature of employee providing the service;
3. Service agency name and contact telephone number;
4. Date of service contact;
5. Start and stop time of service contact;

NOTE: The electronic visit verification (EVV) system will be used to document the start/stop time of service contact. If there is no electronic clock in/out, then paper documentation identifying the exact start and stop times with the date of the service contact is required, including the worker's signature.

6. Place of service contact;
7. Purpose of service contact, including:
 - a. Personal outcomes addressed; and
 - b. Other issues addressed.
8. Content and outcome of service contact.

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

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

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Each support coordination service contact is to be briefly defined (i.e., telephone call, face-to-face visit) with a narrative in the form of a progress note. This documentation should support justification of critical support coordination elements for prior authorization (PA) of service in the data management contractor's system.

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

Progress Notes

Progress notes must be completed by both support coordinators and DSPs at the time of each activity or service. Progress notes summarize the beneficiary's day-to-day activities and demonstrate progress toward achieving their personal outcomes as identified in the approved POC.

Progress notes must be of sufficient content to:

1. Reflect descriptions of activities, procedures, and incidents;
2. Give a picture of the service provided to the beneficiary;
3. Show progress towards the beneficiary's personal outcomes;
4. Record any change in the beneficiary's medical condition, behavior, or home situation which may indicate a need for reassessment and POC change; and
5. Reflect each entry in the service log and/or timesheet.

Checklists alone are not adequate documentation for progress notes.

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

1. "Supported _____.";
2. "Assisted _____.";
3. "_____ is doing fine.";
4. "_____ had a good day."; and

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5. “Prepared meals.”

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

For beneficiaries receiving formal training to learn a specific skill, progress notes must be paired with a skills training data sheet as explained in the OCDD’s “Guidelines for Support Planning” manual. In this instance, the progress notes must document the skills training that occurred and should serve as a pointer to the data collection mechanisms used. (See Appendix D for information on obtaining the *Guidelines for Support Planning*).

Progress Summary

A progress summary is a synthesis of all activities for a specified period which address significant activities, progress toward the beneficiary’s desired personal outcomes, and changes in the beneficiary’s social history. This summary must be of sufficient detail and analysis such that any person reviewing the record can determine if the progress is appropriate and satisfactory based on the beneficiary’s current POC.

The progress summary in the service log may be used by the support coordinators and DSPs to meet the documentation requirements, with the exception of the following:

1. Providers who receive the Individual and Family Support (IFS) services supplemental payment are required to provide additional information and submit that information to the Support Coordinator to continue the supplemental payment.

Progress summaries for individuals receiving additional support due to complex medical or behavioral needs require the following:

1. Behavioral:
 - a. Challenges encountered;
 - b. Methods employed to mitigate;
 - c. Progress in number of incidents or severity of incidents from previous quarter;

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- d. Progress in becoming more independent from previous quarter; and
 - e. Additional services, staff, or credentialed staff required for mitigation of incidents.
2. Medical:
- a. Changes in health status based on a registered nurse (RN) assessment;
 - b. Any charts completed for Non-complex medical tasks;
 - c. Medical appointments and hospitalizations;
 - d. New signs and symptoms to monitor (this would require a revision to Attachments D or L, and training of the direct service worker (DSW)); and
 - e. Training records /RN Delegations for DSW's for the Non-Complex tasks.

If the progress summary is not submitted to the Support Coordination Agency (SCA) quarterly as required, the supplemental payment will be discontinued. A progress summary must be completed at least once every quarter for each beneficiary.

Discharge Summary for Transfers and Closures

A discharge summary details the beneficiary's progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a beneficiary's discharge. The discharge summary in the service log may be used by the support coordinators and DSPs to meet the documentation requirement.

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Individualized Documentation

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

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

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

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

The IFS provider is responsible for collecting all required individualized documentation for the risk factors listed above and making it available to professionals, nursing personnel, and medical personnel providing services to the beneficiary in order to facilitate quality of care. The data collection mechanism (e.g., the form or other collection method) related to these items must be submitted with the beneficiary’s POC and, if altered, with any succeeding revisions. Refer to the OCDD “Guidelines for Support Planning” manual for additional information regarding data collection revision requests, available technical assistance and sample documentation forms.

Schedule of Required Documentation

SUPPORT COORDINATION AGENCIES AND DIRECT SERVICE PROVIDERS			
SERVICE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/TRANSFER
At time of activity	At time of activity	At least once every quarter.	Within 14 calendar days of discharge

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SECTION 32.9: REIMBURSEMENT

REIMBURSEMENT

Reimbursement

Providers of New Opportunities Waiver (NOW) services must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. The service unit is 15 minutes and is reimbursed at a flat rate. Refer to Appendix E for information about procedure/billing codes, unit of services, and current reimbursement rates.

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

All claims for NOW services shall be filed by electronic claims submission 837P or on the Centers for Medicare and Medicaid Services (CMS) 1500 claim form. (See Appendix F for claims related information).

Electronic Visit Verification

An electronic visit verification (EVV) system has been implemented for some NOW services. The following services are required to be electronically clocked in/out of the Louisiana Services Reporting System (LaSRS®). Providers who have an existing EVV program that has been approved by the Office of Citizens with Developmental Disabilities (OCDD) and Bureau of Health Services Financing (BHSF) will be exempted from using the LaSRS® system for these services.

Providers who fail to use an approved EVV system for services may be subject to payment hold and/or denial of reimbursement.

Services in LaSRS® for Electronic Clock In/Out	
Day Habilitation	Individual and Family Support (IFS) (all services)
Employment Related Training	Supported Independent Living (SIL) Monthly Face to Face In-Home Contact
Supported Employment (all services)	Community Integration Development Services
Center-Based Respite (CBR)	Support Coordination
Transportation for Day Habilitation and Supported Employment	

Direct Support Worker Wage Floor

Medicaid has established a Direct Support Worker (DSW) wage floor for Medicaid home and community-based services (HCBS) for intellectual and developmental disabilities. Provider agencies must follow these rules and pay the DSW as directed by Medicaid. The current wage floor can be found in the Louisiana Administrative Code (LAC) and the OCDD will post a memo on the OCDD website (<https://ldh.la.gov/index.cfm/subhome/11/n/8>). Providers will be responsible for following this directive.

PROGRAM MONITORING

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

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

1. Beneficiary's access to needed services identified in the service plan;
2. Quality of assessment and service planning;
3. Appropriateness of services provided including content, intensity, frequency and beneficiary input and satisfaction;
4. Presence of the personal outcomes as defined and prioritized by the beneficiary and/or responsible representative; and
5. Internal quality improvement (IQP).

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

On-Site Reviews

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

1. Ensure compliance with program requirements; and
2. Ensure that services provided are appropriate to meet the needs of the beneficiaries served.

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Administrative Review

The administrative review includes the following:

1. Review of administrative records;
2. Review of other provider agency documentation; and
3. Provider agency staff interviews, as well as interviews with a sampling of beneficiaries, to determine continued compliance with provider participation requirements.

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

Interviews

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

1. Representative sample of the individuals served by each provider agency employee;
2. Members of the beneficiary's circle or network of support, which may include family and friends;
3. Service providers; and
4. Other members of the beneficiary's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency (SCA), direct service providers (DSPs), and other employees of the DSP agency.

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

Personnel Record Review

The personnel record review includes the following:

1. Review of personnel files;

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2. Review of time sheets; and
3. Review of the current organizational chart.

Beneficiary Record Review

A representative sample of beneficiary records are reviewed to ensure the services and supports delivered to beneficiaries are rendered according to the beneficiary's approved plan of care (POC). The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the beneficiaries served.

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

Documentation is reviewed to ensure that the services reimbursed were:

1. Identified in the POC;
2. Provided;
3. Documented properly;
4. Appropriate in terms of frequency and intensity; and
5. Relate back to personal outcomes on the POC.

Provider Staff Interviews

Provider agency staff is interviewed as part of the on-site review to ensure that staff meets the following qualifications:

1. Education;
2. Experience;
3. Skills;
4. Knowledge;

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5. Employment status;
6. Hours worked;
7. Staff coverage;
8. Supervisor to staff ratio;
9. Caseload/beneficiary assignments;
10. Supervision documentation; and
11. Other applicable requirements.

Monitoring Report

Upon completion of the on-site review, HSS staff discuss the preliminary findings of the review in an exit interview with appropriate provider staff. HSS staff compile and analyze 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 the following:

1. Identifying information;
2. Statement of compliance with all applicable regulations; or
3. Deficiencies requiring corrective action by the provider.

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.

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Upon receipt of the written plan of correction, HSS program managers review the provider's plan of correction 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 the right of the provider to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix 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 the time and place of the informal hearing. The provider should bring all supporting documentation that is to be submitted for consideration. Every effort will be made to schedule a hearing at the convenience of the provider.

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

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

Fraud and Abuse

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

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the Inspector General (OIG), Federal Bureau of Investigation (FBI) and postal inspectors also conduct investigations of Medicaid fraud.

Quality Management

DSPs and SCAs must have a quality enhancement process that involves the following:

1. Learning;
2. Responding;
3. Implementing; and
4. Evaluating.

Agency quality enhancement activities must be reviewed and approved by the local governing entity (LGE) as described in the *Quality Enhancement Provider Handbook*. (See Appendix D for information on this handbook).

Support Coordination

Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the beneficiary's approved POC.

Support coordinators shall also participate in the evaluation and re-evaluation of the beneficiary's POC.

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SECTION 32.11: INCIDENTS, ACCIDENTS AND COMPLAINTS

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INCIDENTS, ACCIDENTS AND COMPLAINTS

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

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

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

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

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

NOTE: It is the policy of the Louisiana Department of Health (LDH), OCDD that all critical incidents for home and community-based services (HCBS) be reported, investigated and tracked. The statewide incident management system **MUST** be used for **ALL** critical incident reporting.

Internal Complaint Policy

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

1. 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;

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2. If the complaint is verbal, the provider staff member receiving the complaint must obtain and send all pertinent information in writing to the provider complaint coordinator. If the beneficiary completes the complaint form, they will be responsible for sending the form to the provider complaint coordinator;
3. The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within 5 working days**;
4. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to: gathering pertinent facts from the beneficiary, the personal representative, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution;
5. The provider’s administrator or designee must inform the beneficiary and/or the personal representative in writing **within 10 working days** of receipt of the complaint and the results of the internal investigation; and
6. If the beneficiary is dissatisfied with the results of the internal investigation regarding the complaint, they may continue the complaint resolution process by contacting the appropriate local governing entity (LGE) in writing, or by telephone.

If the complainant’s name and address are known, the LGE will notify the complainant **within 2 working days** that the complaint has been received and action on the complaint is being taken.

Complainant Disclosure Statement

Louisiana R.S. 40:2009.13-40.2009.21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the HCBS waiver programs. When the substance of the complaint is furnished to the service provider, it shall not identify the complainant or the beneficiary unless they consent in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

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

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

Definition of Related Terms Regarding Incidents and Complaints

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

1. 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. (R.S. 40:2009.14);
2. 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 (ADL). (R.S. 40:2009.14);
3. Trivial report - an account of an allegation that an incident has occurred to a beneficiary or beneficiaries that causes no physical or emotional harm and has no potential for causing harm to the beneficiary or beneficiaries. (R.S. 40:2009.14);
4. Allegation of noncompliance - an accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (R.S. 40:2009.14);
5. Abuse - the infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that their health, self-determination, or emotional well-being is endangered. (R.S. 15:1503);
6. 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. (R.S. 15:1503);
7. 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. (R.S. 15:1503);
8. Neglect - the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other

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care necessary for their well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (R.S. 15:1503);

9. 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 their own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (R.S. 15:1503);
10. Sexual abuse - any sexual activity between a beneficiary and staff without regard to consent or injury; any non-consensual sexual activity between a beneficiary and another person; or any sexual activity between a beneficiary and another beneficiary or any other person when the beneficiary 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 beneficiary to perform sex with any other person when beneficiary is not competent to refuse;
11. Disabled person - a person with a mental, physical or developmental disability that substantially impairs the person's ability to provide adequately for their own care or protection; and
12. Incident - any situation involving a beneficiary that is classified in one of the categories listed in this section or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the beneficiary or affect delivery of waiver services.

SUPPORT COORDINATION

Support coordination, which is also referred to as case management, is a waiver service that is provided to all Louisiana Waiver beneficiaries. Support coordination is an organized system by which a support coordinator assists a beneficiary to prioritize and define their personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Beneficiaries may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies (SCAs) are required to perform the following:

1. Intake;
2. Assessment;
3. Plan of care (POC) development and implementation;
4. Follow-up/monitoring;
5. Reassessment; and
6. Transition/closure.

Intake

The local governing entity (LGE) serves as an entry point for Louisiana Medicaid Developmental Disabilities Waiver services. When criteria are met, the beneficiaries' names are placed on the registry. All waiver participants choose their support coordination and direct services provider (DSP) agencies through the Freedom of Choice (FOC) process. The Office for Citizens with Developmental Disabilities (OCDD) will offer the most appropriate waiver based on person-centered planning and a needs-based assessment. As part of the tiered waiver process guidelines, OCDD will offer the most appropriate waiver based on person-centered planning and a needs-based assessment. All children under age 21 enter the waiver system into the Children's Choice (CC) Waiver and all adults enter with current unmet needs into the Supports Waiver (SW). If an individual's needs cannot be met with the initial waiver they may request moving up to the next waiver in the tier. The NOW is the final tier within the OCDD Tiered Waiver process.

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Referrals for support coordination services are only made from OCDD through the Medicaid data contractor. The applicant must be interviewed to obtain the required demographic information, preferably face-to-face in the applicant's home, within 3 working days of receipt of the FOC form.

The POC process begins with an initial face-to-face meeting in the beneficiary's home. The support coordinator requests and gathers medical, social, educational and psychological documentation necessary to complete the POC. The local LGE will transfer eligibility documents with the transfer of records to the support coordination agency. Prior authorization (PA) to cover services from the beginning date of the POC will be issued upon approval of the POC.

The support coordinator must determine whether the applicant:

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

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

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

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

1. Informed of procedural safeguards;
2. Informed of their rights along with grievance procedures;
3. Advised of their responsibilities;
4. Accepted support coordination service;
5. Advised of the right to change support coordination providers, support coordinators, service providers; and

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

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

Assessment

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

Assessment Process

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

1. Face-to-face home interviews with the beneficiary/beneficiary's family or guardian/authorized representative;
2. Direct observation of the beneficiary;
3. Direct contact with family, other natural supports, professionals and support/service providers as indicated by the situation and the desires of the beneficiary; and
4. FOC of all services, support coordination and alternative to institutionalization.

Characteristics and components of the assessment include:

1. Identifying information (demographics);
2. The use of a standardized instrument for certain targeted populations;
3. Personal outcomes identified, defined and prioritized by the beneficiary;

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4. Medical/physical information;
5. Psycho social/behavioral information;
6. Developmental/intellectual information;
7. Socialization/recreational information including the social environment and relationships that are important to the beneficiary;
8. Patterns of the beneficiary's everyday life;
9. Financial resources;
10. Educational/day and/or employment information;
11. Housing/physical environment of the beneficiary;
12. Information about previously successful and unsuccessful strategies to achieve the desired personal outcomes;
13. Information relevant to understanding the supports and services needed by the beneficiary to achieve the desired personal outcomes, (e.g., input from formal and informal service providers and caregivers as relevant to the personal outcomes); and
14. Identification of areas where a professional evaluation is necessary to determine appropriate services or interventions.

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

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

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The initial assessment must begin **within 7 calendar days** and be completed **within 30 calendar days** following the referral/linkage.

Ongoing Assessment Procedures

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

Plan of Care Development and Implementation

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

The POC is developed through a collaborative process involving the beneficiary and the persons who the beneficiary chooses to participate in the process that may include, family, friends or other support systems, the support coordinator and appropriate professionals/service providers and others who know the beneficiary best.

The purpose of the POC is to:

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

The POC should not be considered a treatment plan of specific clinical interventions that service providers would use to achieve treatment or rehabilitation goals. Instead, the POC should be

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considered a “master plan” consisting of a comprehensive summary of information to aid the beneficiary to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining the desired personal outcomes of the beneficiary.

Required Procedures

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

The POC must be outcome-oriented, individualized and updated at least annually. The planning process should include tailoring the POC to the beneficiary’s needs and desires based on the ongoing personal outcomes assessment. It must develop mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services. The beneficiary, support coordinator, members of the support system, DSPs, and appropriate professional personnel must be directly involved in the development of the POC.

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

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

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

Required Components

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

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1. Beneficiary'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;
2. Budget payment mechanism, as applicable;
3. Target/resolution dates for the achievement/maintenance of personal outcome;
4. Assigned responsibilities;
5. Identified preferred formal and informal support/service providers and the specific service arrangements;
6. Identified individuals who will assist the support coordinator in planning, building/implementing supports, or direct services;
7. Ensured flexibility of frequency, intensity, location, time and method of each service or intervention and is consistent with the POC and beneficiary's desired outcomes;
8. Change in a waiver service provider(s) can only be requested by the beneficiary at the end of a 6 months linkage unless there is "good cause." Any request for a change requires a completion of a FOC form. A change in support coordination providers is to be made through the Medicaid data contractor. A change in DSPs is to be made through the support coordinator;
9. All participants present at the POC meeting must sign the POC;
10. The POC must be completed and approved as per POC instructions; and
11. The beneficiary must be informed of their right to refuse a POC after carefully reviewing it.

Building and Implementing Supports

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

Responsibilities of the support coordinator include:

1. Building and implementing the supports and services as described in the POC;

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2. Assisting the beneficiary/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 beneficiary in the POC;
3. Being aware of and providing information to the beneficiary/family on potential community resources, including formal resources (Supplemental Nutrition Assistance Program (SNAP) Benefits, Supplemental Security Income, housing, Medicaid, Benefits Planning, etc.) and informal/natural resources, which may be useful in developing strategies to support the beneficiary in attaining their desired personal outcomes;
4. Assisting with problem solving with the beneficiary, supports, and services providers;
5. Assisting the beneficiary to initiate, develop, and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet the beneficiary's individual needs and desires;
6. Advocating on behalf of the beneficiary to assist in obtaining benefits, supports, or services, e.g., to help establish, expand, maintain and strengthen the beneficiary's informal and natural support networks by calling and/or visiting beneficiaries, community groups, organizations, or agencies with or on behalf of the beneficiary;
7. Training, supporting and/or connecting the beneficiary in self-advocacy groups, e.g., selection of providers and utilization of community resources to achieve and maintain the desired outcomes;
8. Overseeing the service providers to ensure that the beneficiary receives appropriate services and outcomes as designed in the POC;
9. Assisting the beneficiary to overcome obstacles, recognize potential opportunities, and develop creative opportunities;
10. Monthly phone calls with the beneficiary, and
11. Meeting with the beneficiary face-to-face in the beneficiary's home for each initial and/or annual POC development, and at least one other quarterly meeting or more often if requested by the beneficiary/family. If the beneficiary meets the criteria for virtual visits, the remaining 2 quarterly meetings may be completed using a virtual delivery format.

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

Required Time Frames

1. **Linkage:** The initial POC must be completed and received by the LGE within 35 calendar days following the date of the notification of linkage by the data contractor. All incomplete packages will be returned;
2. **Revisions to the POC:** Routine changes, such as vacations or when school is not in session, must be submitted 7 working days prior to the change;
3. **Emergencies:** Emergency changes must be submitted within 24 hours or the next working day following the change; and
4. **Reviews:**
 - a. The POC must be reviewed after implementation to ensure that the personal outcomes and support strategies are consistent with the needs and desires of the beneficiary; and
 - b. The POC must be revised annually (and as required) and submitted to the LGE no later than 35 days prior to expiration. The POC may be submitted as early as 60 days prior to expiration provided the form 90-L does not expire prior to the POC expiration date.

Changes in the Plan of Care

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

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

Initiating a Change in the Plan of Care

The beneficiary/family will contact the support coordinator when a change is required. The support coordinator will call a meeting with the service provider to complete the POC revision form. All participants will sign the POC revision, and it will be submitted to the LGE for

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approval. The support coordinator will notify the service provider and beneficiary of the approval/disapproval.

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

Documentation

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

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

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

Follow-Up/Monitoring

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

The purpose of the follow-up/monitoring contacts is to determine:

1. If services are being delivered as planned;
2. If services are effective and adequate to meet the beneficiary's needs; and
3. Whether the beneficiary is satisfied with the services.

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

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

1. Does the beneficiary/family feel the outcomes are being met;
2. Are the times the services are being provided convenient and satisfactory to the beneficiary/family;

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3. Does the beneficiary/family have any problems or changes that may require additional services;
4. Are the providers actually present at the times indicated; and
5. Are the provided services adequate and of good quality.

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

Notify service providers within 3 working days of written changes in the POC.

Meet with the beneficiary between the 6th and 9th month of implementation of the POC to determine the effectiveness of the support strategies and, if necessary, to revise the POC.

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

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

1. Desired personal outcomes;
2. Strategies to achieve the outcomes;
3. Effectiveness of the strategies;
4. Obstacles to achieving the desired outcomes;
5. New opportunities; and
6. Developing a new action plan.

Reassessment

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

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A reassessment is required when a major change occurs in the status of the beneficiary, the beneficiary's family, or the beneficiary's prioritized needs. A reassessment must be completed **within 7 calendar days** of notice of a change in the beneficiary's status.

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

Annual Reassessment

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

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

1. The beneficiary's health and welfare can be assured;
2. There are no changes in waiver services; and
3. The current waiver services are meeting the needs of the beneficiary.

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

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

1. Skilled nursing care;
2. Direct service worker (DSW) given delegation for medication administration or delegation for a complex or non-complex task;
3. Crisis or non-crisis designation was requested;
4. There were 3 or more critical incident reports during the POC year; or

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5. There was any report with a substantiated investigation to the Department of Children and Family Services' (DCFS) Child Welfare Division or the Louisiana Department of Health's (LDH's) Adult Protective Services.

Transition/Closure

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

Closure Criteria

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

1. Beneficiary requests termination of services;
2. Death;
3. Permanent relocation of the beneficiary out of the service area (transfer to another region) or out of state;
4. Long term admission to an institution or nursing facility;
5. The beneficiary requires a level of care (LOC) beyond that which can safely be provided through waiver services; or
6. Beneficiary refuses to comply with support coordination.

Procedures for Transition/Closure

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

Support coordinators must:

1. Notify the beneficiary/family immediately if the beneficiary becomes ineligible for services;

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

The support coordination agency must:

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

NOTE: An agency shall not close a beneficiary's case that is in the process of an appeal.

Only upon receipt of the appeal decision may the case be closed. If an appeal is requested within ten days, the case remains open. If not requested within ten days, the case will be closed.

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

Changing Support Coordination Agencies

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

1. Complete the FOC file transfer;
2. Obtain the case record and authorized signature;
3. Inform the transferring SCA; and

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4. Upon receipt of the completed form, the transferring provider must provide copies of the following information:
 - a. Most current POC;
 - b. Current assessments on which the POC is based;
 - c. Number of services used in the calendar year;
 - d. Most recent 6 months of progress notes; and
 - e. Form 90-L.

The transferring support coordination provider shall provide services up to the transfer of the records and is eligible to bill for support coordination services after the dated notification is received (transfer of records) by the receiving agency. In the month the transfer occurs, the receiving agency shall begin services within 3 days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. The receiving agency must submit the required documentation to the LGE /Medicaid contractor to begin PA immediately after the transfer of records.

Other Support Coordination Responsibilities

Assistance with Self-Direction Option

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

1. Training beneficiaries on their responsibilities as an employer;
2. Completing required forms for participation in the self-direction option;
3. Assisting with development of back-up service plan;
4. Assisting with development of budget planning;
5. Verifying potential employees meet program qualifications;
6. Ensuring the beneficiary's needs are being met through services; and
7. Monitoring the beneficiary's self-directed services face-to-face each quarter.

Reporting of Incidents, Accidents and Complaints

The support coordinator must report and document any complaint, incident, accident, suspected case of abuse, neglect, exploitation or extortion to the OCDD, Health Standards Section (HSS), and other appropriate agency as mandated by law. All suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion must be reported to the appropriate authorities. Refer to Section 38.11 – Incidents, Accidents and Complaints for additional instructions.

DEVELOPMENTAL DISABILITY LAW

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

1. A severe chronic disability of a person that:
 - a. Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;
 - b. Is manifested before the person reaches age 22);
 - c. Is likely to continue indefinitely;
 - d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
 - i. Self-care;
 - ii. Receptive and expressive language;
 - iii. Learning;
 - iv. Mobility;
 - v. Self-direction;
 - vi. Capacity for independent living; or
 - vii. Economic self-sufficiency.
 - e. Is not attributed solely to mental illness; and
 - f. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

OR

2. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age 9 which, without services and support, has a high

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APPENDIX A – DEVELOPMENTAL DISABILITY LAW

probability of resulting in those criteria listed above later in life that may be considered to be a developmental disability.

GLOSSARY

The following is a list of abbreviations, acronyms and definitions used in the New Opportunities Waiver (NOW) manual chapter:

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

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

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

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

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

Appeal – A due process system of procedures, which ensures that a beneficiary will be notified of, and have an opportunity to contest, a Louisiana Department of Health (LDH) decision.

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

Assessment – One or more processes used to obtain information about a person, including their condition, personal goals and preferences, functional limitations, health status, and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person requires waiver services as well as the development of the plan of care (POC).

Authorized Representative – A person designated by a beneficiary (by use of a designation form) to act on their behalf with respect to their services.

Behavior Management Plan – A plan that addresses a beneficiary’s specific behavior, or set of behaviors, and is written by a licensed psychologist and updated at least annually.

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

Bureau of Health Services Financing (BHSF) – The Bureau LDH responsible for the administration of the Louisiana Medicaid Program.

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

Claim – A request for payment for services rendered.

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

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

Corrective Action Plan (CAP) – Written description of action a direct service provider (DSP) agency plans to take to correct deficiencies identified by the local governing entity (LGE), Office for Citizens with Developmental Disabilities (OCDD) or LDH.

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

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

Developmental Disability – See Appendix A.

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

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

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

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

Durable Medical Equipment (DME) – Long-lasting apparatus and supplies covered under the Medicaid State Plan.

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

Electronic Visit Verification (EVV) – A computer based system that records the actual time the provision of waiver services begins and ends. Louisiana Service Reporting System (LaSRS®) is the state sponsored system that is mandatory for some waiver services, as identified in the program manual. Providers may request permission from BHSF and OCDD to use their own EVV system for mandatory services. Approval will only be granted for EVV systems that meet minimum standards established by the department.

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

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

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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.

Extraordinary Care - Defined as exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

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

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

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

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

Home and Community-Based Services (HCBS) – An optional Medicaid waiver 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 LOC. 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.

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

Individualized Service Plan (ISP) – The ISP has been replaced by the provider documents contained in the POC. See the definition for POC.

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A public or private facility that provides health and habilitation services to people with intellectual disabilities. ICFs/IID have 4 or more beds and provide “active treatment” to their residents.

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

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

Linkage – The act of connecting a beneficiary to a specific support coordination or service provider agency.

Local Governing Entity (LGE) – The regional office, routinely referred to as the human services authority or district responsible for single point of entry, implementation, and oversight of the Residential Options Waiver on behalf of OCDD. There is one LGE for each service region. Refer to Appendix C to obtain the contact information for the LGE in your area.

Louisiana Department of Health (LDH) – The state agency responsible for administering the state’s Medicaid program and other health and related services including, but not limited to, public health, behavioral health, developmental disabilities, and addictive disorder services.

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

LTC – Long-Term Care.

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

Medical Eligibility Determination Form (90-L) – The form that is signed by a Louisiana licensed physician, nurse practitioner (NP), or physician assistant and used by Medicaid to establish a LOC. In the NOW program, a beneficiary must meet an ICF/IID LOC in order to be offered a waiver opportunity.

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

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

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Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary’s ADL. (La. R.S.40.2009.14).

Monitoring – The ongoing oversight of the provision of waiver services to ensure that they are furnished according to the beneficiary’s approved POC and effectively meet their needs.

Multi-disciplinary Team (MDT) – The group of professionals involved in assessing the needs of a high risk beneficiary and making recommendations in a team staffing for services or interventions targeted at those needs which is also referred to as Interdisciplinary Team (IDT).

Native Language – The language normally used by the beneficiary and their support network, which may include, but not limited to, American or English sign language and other non-verbal forms of communication.

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

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

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

New Opportunities Waiver (NOW) – A 1915(c) waiver program designed to provide HCBS to beneficiaries who otherwise would require the LOC of an ICF/IID.

Office for Citizens with Developmental Disabilities (OCDD) – The operating agency responsible for the state-wide day-to-day operation and administration of the NOW program.

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

Person-Centered Planning – A POC process directed and led by the beneficiary or their authorized representative designed to identify their strengths, capacities, preferences, needs, and desired outcomes.

Personal Outcomes – Results achieved by, or for, the waiver beneficiary through the provision of services and supports that make a meaningful difference in the quality of their life.

Plan of Care (POC) – A written plan designed by the beneficiary, their authorized representative, service provider(s), and others chosen by the beneficiary, and facilitated by the support coordinator which lists all paid and unpaid supports and services. It also identifies broad goals and timelines identified by the beneficiary as necessary to achieve their personal outcomes. Also included in the POC are specific actions required by the provider agency to assist in achieving the personal outcomes defined by the beneficiary are, as well as tasks to support daily living and ensure health and safety.

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

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

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

Prior Authorization (PA) - The authorization for service delivery based on the beneficiary's approved POC. PA must be obtained before any waiver services can be provided and post authorization must be approved before services delivered will be paid.

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

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

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

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

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

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

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 beneficiary.

Request for Services Registry (RFSR) – The database that contains the demographic information, screening score(s), and protected waiver request date(s) for all individuals who request waiver services through OCDD.

Screening for Urgency of Need (SUN) – The current tool used by OCDD to determine the urgency of need of individuals on the RFSR. The score received on the SUN is used for prioritization in making waiver offers.

Self-Neglect – The failure, by either the adult’s action or inaction, to provide the proper or necessary support or medical, surgical or any other care 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. RS 15:1503).

Sexual Abuse – Any sexual activity between a beneficiary and staff without regard to consent or injury; any non-consensual sexual activity between a beneficiary and another person, or any sexual activity between a beneficiary and another beneficiary, or any other person when the beneficiary 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 beneficiary to perform sex with any other person when beneficiary is not competent to refuse.

Single Point of Entry (SPOE) – The LGE where the entry point for all developmental disability services, including HCBS waivers, is made.

Statement of Approval (SOA) – Statement issued by the SPOE confirming the date the individual has been determined to meet the Louisiana definition for developmental disability.

Support Coordination – Case management services provided to eligible waiver beneficiaries to help them gain access to the full range of needed services including medical, social, educational and other support services. Activities include, but are not limited to, assessment, POC development, service monitoring, and assistance in accessing waiver, Medicaid State Plan and other non-Medicaid services and resources.

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

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

Surveillance Utilization Review System (SURS) – The program operated by the Medicaid fiscal intermediary (FI) in partnership with the Program Integrity Section, which reviews providers’ compliance with Louisiana Medicaid policies and regulations, including investigating allegations of fraud, waste, and abuse.

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

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

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

Waiver Service – An approved service in a HCBS waiver provided to an eligible beneficiary that is designed to supplement, not replace, the beneficiary’s natural supports.

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APPENDIX C: CONTACT INFORMATION

CONTACT/REFERRAL INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Office for Citizens with Developmental Disabilities (OCDD) Central Office	Operating agency responsible for the statewide operation and administration of the OCDD waiver programs.	Office for Citizens with Developmental Disabilities (OCDD) PO Box 3117, Bin #21 Baton Rouge, LA 70821-3117 Phone: (225) 342-0095 Toll-Free: 1-866-783-5553 Fax: (225) 342-8823 E-Mail: ocddinfo@la.gov
Human Service Districts and Authorities	Regional office responsible for Single Point of Entry (SPOE), implementation and oversight of the New Opportunities Waiver (NOW) on behalf of OCDD.	http://ldh.la.gov/index.cfm/page/134
Health Standards Section (HSS)	Office to contact to report changes that affect provider license.	Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 or (225) 342-0138 Fax: (225) 342-5073
Division of Administrative Law (DAL) – Louisiana Department of Health (LDH)	Office to contact to file an appeal request.	Division of Administrative Law - LDH P. O. Box 44033 Baton Rouge, LA 70804-4033 (225) 342-1800 Fax: (225) 342-1812
Healthy Louisiana (MEDICAID MANAGED CARE ORGANIZATIONS (MCO)	Healthy Louisiana (previously called Bayou Health) is the way most of Louisiana's Medicaid and LaCHIP beneficiaries receive health care services. In Healthy Louisiana, Medicaid beneficiaries enroll in a managed care plan.	http://ldh.la.gov/index.cfm/subhome/6

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APPENDIX C: CONTACT INFORMATION

<p>Medicaid Program Integrity (PI)</p>	<p>Office to contact to report fraud, waste or abuse.</p>	<p>Program Integrity (PI) Section P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://ldh.la.gov/index.cfm/page/219</p>
<p>Louisiana State Adverse Actions List Search with Direct Service Worker (DSW) Registry information</p> <p>And</p> <p>Office of the Inspector General (OIG)</p>	<p>Verification of exclusion or restriction from government funded health program and verification of findings which excludes DSW from working with waiver participants.</p> <p>Note: Provider MUST search both for each worker upon hire and every month thereafter and must maintain documentation of these checks.</p>	<p>https://adverseactions.dhh.la.gov/</p> <p>and</p> <p>https://exclusions.oig.hhs.gov/</p>
<p>Federal System Award Management</p>	<p>Verification of exclusion or restriction of Vendors from government funded programs.</p> <p>Note: Provider MUST search upon hire and every month thereafter and must maintain documentation of these checks.</p>	<p>https://www.sam.gov/portal/SAM/</p>
<p>Gainwell Technologies Provider Enrollment Section</p>	<p>Office to contact to report changes in agency ownership, address, telephone number, account information, etc.</p>	<p>Gainwell Technologies Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370</p>
<p>Gainwell Technologies) Provider Relations Unit</p>	<p>Office to contact to obtain assistance with questions regarding Medicaid billing information.</p>	<p>Gainwell Technologies Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or 225-924-5040</p>

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<p>Department of Children and Family Services (DCFS) - Local Child Protection Hotline</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation, or extortion of a beneficiary under the age of 18.</p>	<p>Refer to the DCFS website at: http://www.dss.la.gov under the “Child Welfare” Report Child Abuse/Neglect” link</p>
<p>Adult Protective Services</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation, or extortion of a beneficiary age 18-59 or an emancipated minor.</p>	<p>LDH Office of Aging and Adult Services (OAAS) 1-800-898-4910</p>
<p>Elderly Protective Services</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation, or extortion of a beneficiary age 60 or older.</p>	<p>Governor’s Office of Elderly Affairs 1-833-577-6532</p>
<p>Myers and Stauffer’s, LLC</p>	<p>Information about filing cost reports.</p>	<p>http://www.mslc.com/Louisiana/HCBSDownloads.aspx</p>
<p>Statistical Resources, Inc.</p>	<p>Entity to contact regarding: 1. LAWRRIS; 2. LAST; 3. CMIS; 4. LaSRS; 5. EVV Process; and 6. PA Billing Issues.</p>	<p>11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501</p>

FORMS

The following forms used in the New Opportunities Waiver (NOW) Program are posted on the Louisiana Department of Health (LDH) website at:

<http://ldh.la.gov/index.cfm/newsroom/detail/1564>

1. Environmental Accessibility Adaptation (EAA) Job Completion Form;
2. Specialized Medical Equipment and Supplies (SMES) Purchase and Repair Form;
3. Rights and Responsibilities for Individuals Requesting Home and Community-Based Services (HCBS) Waiver;
4. Transitional Expenses Planning and Approval (TEPA) Request Form;
5. NOW TEPA Invoice Form;
6. Office for Citizens with Developmental Disabilities (OCDD) Verification of Actual TEPA Costs;
7. Universal Plan of Care (POC) including provider documents;
8. LDH-OCDD Revision Request Form – NOW;
9. NOW Comprehensive Plan of Care (CPOC) Revision Request Form Instructions; and
10. OCDD 90-L Medical Eligibility form documenting level of care (LOC) for services Beneficiary’s Consent for Authorized Representation.

Web Reference Information

Information for **support planning** can be obtained from the OCDD *Guidelines for Support Planning* at the following LDH website:

http://ldh.la.gov/assets/docs/OCDD/waiver/NOW/Guidelines_Support_Planning.pdf

Information about **reporting critical incidents** can be obtained from the OCDD *Critical Incident Reporting for Waiver Services* at the following LDH website:

<http://ldh.la.gov/assets/docs/OCDD/waiver/CIRforWaiver-Form.pdf>

The *Quality Enhancement Provider Handbook* can be obtained from the LDH website:
<http://ldh.la.gov/assets/docs/OCDD/waiver/QEProviderHandbook080108.pdf>

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APPENDIX E: SERVICE PROCEDURE CODES/RATES

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SERVICE PROCEDURE CODES/RATES

The New Opportunities Waiver (NOW) Rate and Procedure Codes may be located at the following link:

https://www.lamedicaid.com/Provweb1/fee_schedules/OCDD_NOW.pdf

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APPENDIX F – CLAIMS RELATED INFORMATION

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CLAIMS RELATED INFORMATION

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:

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

Services may be billed using:

1. The rendering provider's individual provider number as the billing provider number for independently practicing providers; or
2. The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a 'group/clinic' practice.

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

Providers are responsible for complying with the requirements in Chapter 1, "General Information and Administration Provider Manual" of the Medicaid Services Manual. This manual is available on the Louisiana Medicaid website under the "Provider Manuals" tab or at: www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf.

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This appendix includes the following:

1. Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
2. Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

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CMS-1500 (02/12) INSTRUCTIONS FOR
HOME AND COMMUNITY – BASED WAIVER SERVICEShttp://www.lamedicaid.com/provweb1/billing_information/CMS_1500_Waiver.pdf

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an "X" in the box marked Medicaid (Medicaid #).	You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.
1a	Insured's Identification (ID) Number	Required – Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears when checking beneficiary eligibility through the Medicaid Eligibility Verification System (MEVS), eMEVS, or Recipient Eligibility Verification System (REVS). NOTE: The beneficiaries' 13-digit Medicaid ID number must be used to bill claims. The card control number (CCN) number from the plastic ID card is NOT acceptable. The ID number must match the beneficiary's name in Block 2.	
2	Patient's Name	Required – Enter the beneficiary's last name, first name, middle initial (MI).	
3	Patient's Date of Birth (DOB) Sex	Situational – Enter the beneficiary's DOB using 6 digits (MM DD YY). If there is only 1 digit in this field, precede that digit with a 0 (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the beneficiary.	
4	Insured's Name	Situational – Complete correctly if the beneficiary has other insurance; otherwise, leave blank.	
5	Patient's Address	Optional – Print the beneficiary's permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured's Address	Situational – Complete if appropriate or leave blank.	

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APPENDIX F – CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
8	RESERVED FOR NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) USE	Leave Blank	
9	Other Insured’s Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured’s Policy or Group Number	<p>Situational – If beneficiary has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the state assigned 6-digit third party liability (TPL) carrier code is required in this block. The carrier code is indicated on the MEV) response as the Network Provider Identification Number.</p> <p>Make sure the explanation of benefits (EOBs) or EOBs from other insurance(s) are attached to the claim.</p>	<p>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</p>
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient’s Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured’s Policy Group or Federal Employees Compensation Act (FECA) Number	Situational – Complete if appropriate or leave blank.	
11a	Insured’s DOB Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	

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APPENDIX F – CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
12	Patient’s or Authorized Person’s Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured’s or Authorized Person’s Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabeled	Situational – Complete if applicable.	
17b	National Provider Identifier (NPI)	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
21	<p>International Classification of Diseases (ICD) Indicator</p> <p>Diagnosis or Nature of Illness or Injury</p>	<p>Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required – Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10- codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page at (www.lamedicaid.com)</p>

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
22	Resubmission Code	<p>Situational. If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field.</p> <p>Enter the internal control number (ICN) from the paid claim line as it appears on the remittance advice (RA) in the “Original Ref. No.” portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = TPL Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>VOIDS</u> 10 = Claim Paid for Wrong Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS-1500 (02/12).</p> <p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different ICN.</p>
23	Prior Authorization (PA) Number	Required – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	Situational	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	Required -- Enter the appropriate place of service code for the services rendered.	
24C	Electromyography (EMG)	Leave Blank.	
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</p> <p>If a modifier(s) is required, enter the appropriate modifier in the correct field.</p>	

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
24E	Diagnosis Pointer	Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	Amount Charged	Required -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D.	
24H	Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	ID Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider ID Number	Situational – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is required . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is when the 7-digit provider number is entered in the shaded portion.	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax ID Number	Optional.	
26	Patient’s Account Number	Situational – Enter the provider specific identifier assigned to the beneficiary. This number will appear on the RA. It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
29	Amount Paid	Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter ‘0’ if the third party did not pay. If TPL does not apply to the claim, leave blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	Optional -- The practitioner or the practitioner’s authorized representative’s original signature is no longer required. Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone Number	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required – Enter the billing provider’s 10-digit NPI number.	
33b	Unlabeled	Required – Enter the billing provider’s 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.	The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.

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

Sample forms are on the following pages

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

SAMPLE WAIVER CLAIM FORM WITH ICD-10 DIAGNOSIS CODE

(DATES ON OR AFTER 10/01/15)



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS										3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 M <input checked="" type="checkbox"/> F									
4. INSURED'S NAME (Last Name, First Name, Middle Initial)										5. PATIENT'S ADDRESS (No., Street)									
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street)									
8. RESERVED FOR NUCC USE										9. RESERVED FOR NUCC USE									
CITY STATE										CITY STATE									
ZIP CODE TELEPHONE (include Area Code)										ZIP CODE TELEPHONE (include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable										a. EMPLOYMENT? (Current or Previous) YES NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? PLACE (State) YES NO									
c. RESERVED FOR NUCC USE										c. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO <i>If yes, complete items 9, 9a and 9d.</i>									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										15. OTHER DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES YES NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. G5 10 B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER Prior Auth#									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD QUAL I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
1 10 08 15 10 08 15 12 S5125 UN A 90 00 30 NPI																			
2 10 09 15 10 09 15 12 S5125 UN A 75 00 25 NPI																			
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. 1234									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO										28. TOTAL CHARGE \$ 165 00									
29. AMOUNT PAID \$										30. BALANCE DUE \$ 165 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ima Biller DATE 10/15/15										32. SERVICE FACILITY LOCATION INFORMATION HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000									
33. BILLING PROVIDER INFO & PH# (225) 555-4957										a. 123967654 b. 1239876									

EXAMPLE OF ICD 10

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION**PAGE(S) 13**

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

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

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

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

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim. Providers are required to submit adjustment claims for all PAID services that are adjusted in their Electronic Visit Verification (EVV) system or Louisiana Services Reporting System (LaSRS); or
2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history. The timely filing requirements apply to resubmitted claims that were previously voided (one year from date of service).

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

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION**PAGE(S) 13**

Adjustments/Voids Appearing on the RA

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

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

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

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

BILLING FOR SERVICES ON HOSPITAL ADMIT/DISCHARGE DATES

Claims for waiver services that overlap with a hospital stay will be denied with a 508 denial code. In order for the claim to be considered for reimbursement, the claim must be submitted manually. The following documentation must be submitted in order to receive payment for services rendered:

1. Hospital admission and discharge paperwork. The date **AND** time of admit and/or discharge must be clearly denoted on the hospital paperwork with the beneficiary's name;
2. Timesheets for date of admit/discharge;
3. Service logs for date of admit/discharge; and
4. Properly completed CMS-1500 claim form for services provided as instructed previously in this section.

Mail claim form and supporting documentation to:

Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD)

Attn: Provider Program Manager

P.O. Box 3117, Bin 21

Baton Rouge, LA 70821-3117


Keep a copy of all claim forms and supporting documentation for your files.

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

Sample forms are on the following pages.

SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)

 **WAIVER**

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

PICA PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK/LUNG OTHER (Medicare #) (Medicaid #) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)				1a. INSURED'S I.D. NUMBER (For Program in item 1) 9876543210123			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS				3. PATIENT'S BIRTH DATE MM DD YY 07 31 72		SEX M X F	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? PLACE (State) c. OTHER PROCEDURE 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED DATE				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED DATE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. G5 10 B. C. D. E. F. G. H. I. J. K. L.				22. RESUBMISSION CODE ORIGINAL REF. NO. A02 5299198798700			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAY'S OR UNITS H. ICD ID. QUAL. I. ID. QUAL. J. RENDERING PROVIDER ID. #				23. PRIOR AUTHORIZATION NUMBER Prior Auth#			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO. 1234		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO	
28. TOTAL CHARGE \$ 90 00				29. AMOUNT PAID \$		30. BALANCE DUE \$ 90 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ima Biller DATE 10/15/15				32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000	
34. a. 123967654 b. 1239876							

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

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS RELATED INFORMATION

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <input type="checkbox"/> PICA																																																																																																																																																																																															
1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#/DD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLX (LUNG) <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																																																																																																																										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																						
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		8. RESERVED FOR NUCC USE																																																																																																																																																																																						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d.		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____ DATE _____																																																																																																																																																																																				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____					15. OTHER DATE QUAL. _____ MM DD YY 17a. _____ 17b. NPI _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____																																																																																																																																																																																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____																																																																																																																																																																																															
<table border="1"> <thead> <tr> <th colspan="3">24. A. DATE(S) OF SERVICE</th> <th colspan="2">B. PLACE OF SERVICE</th> <th colspan="2">C. EMG</th> <th colspan="3">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">E. DIAGNOSIS POINTER</th> <th colspan="2">F. \$ CHARGES</th> <th colspan="2">G. DAYS OF PT. Plan</th> <th colspan="2">H. I.D. QUAL.</th> <th colspan="2">J. RENDERING PROVIDER ID. #</th> </tr> <tr> <th>From</th> <th>To</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>CPT/HCPCS</th> <th>MODIFIER</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>MM DD YY</td> <td>MM DD YY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>												24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF PT. Plan		H. I.D. QUAL.		J. RENDERING PROVIDER ID. #		From	To						CPT/HCPCS	MODIFIER												MM DD YY	MM DD YY																			1																				2																				3																				4																				5																				6																			
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OF PT. Plan		H. I.D. QUAL.		J. RENDERING PROVIDER ID. #																																																																																																																																																																													
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25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> SBN EIN <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____		30. Ravel for NUCC Use																																																																																																																																																																																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____					33. BILLING PROVIDER INFO & PH # ()																																																																																																																																																																																					

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