PERSONAL CARE SERVICES PROVIDER MANUAL

Chapter Thirty of the Medicaid Services Manual

Issued November 1, 2009

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

State of Louisiana
Bureau of Health Services Financing
## PERSONAL CARE SERVICES

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OVERVIEW

The Department of Health and Hospitals (DHH) established Long Term-Personal Care Services (LT-PCS) as an optional service under the Medicaid State Plan. This program is designed for Medicaid recipients who require assistance with the activities of daily living and are either in a nursing home or at imminent risk of nursing facility placement.

The purpose of LT-PCS is to assist individuals with functional impairments with their daily living activities. LT-PCS must be prior authorized and provided in accordance with an approved Plan of Care and supporting documentation. In addition, LT-PCS must be coordinated with the other Medicaid services, community services and informal supports being provided to the recipient and will be considered in conjunction with those services.

Each person requesting LT-PCS will undergo a functional eligibility screening to determine if both nursing facility level of care is met and nursing facility admission is imminent.

LT-PCS applicants who have been determined to meet nursing facility level of care and who are at imminent risk of nursing facility placement are assessed face-to-face using the Minimum Data Set – Home Care (MDH-HC). This face-to-face MDS-HC assessment is utilized to:

• Verify eligibility qualifications,
• Determine resource allocation, and
• Identify the individual’s need for support in performance of activities of daily living (ADL) and instrumental activities of daily living (IADL).

The services offered under the LT-PCS program are provided by a Medicaid enrolled agency that has a valid Home and Community-Based Services license issued by the Department of Health and Hospitals’ Health Standards Section (HSS).
COVERED SERVICES

Long Term-Personal Care Services (LT-PCS) are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADL) and the instrumental activities of daily living (IADL). Once program requirements are met, assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by himself/herself.

Service Definitions

ADL are personal, functional activities required by the recipient. They include the following tasks:

- Bathing – verbal reminder to take a bath, preparation of the bath, assistance in and out of the bath/shower, and/or physical assistance with bathing and/or drying off;
- Grooming – verbal reminder to do the task, assistance with shaving, application of make-up and/or body lotion or cream, brushing or combing hair, brushing teeth and/or other grooming activities;
- Dressing – verbal reminder to do the task, and/or physical assistance with putting on clothing;
- Ambulation – assistance with walking (regardless of assistive device);
- Eating – verbal reminder to eat, cutting up food, partial assistance with feeding, and/or assistance with adaptive feeding devices (not to include tube feeding);
- Transferring – assistance with moving from one surface to another (excluding on/off commode and into/out of tub or shower);
- Toileting – verbal reminder to toilet, assistance with bladder and/or bowel requirements, including bedpan routines and changing pads or adult briefs, if required. This does not include insertion or removal of a catheter; and
- Bed mobility.

IADL are routine tasks that are considered essential, but may not require performance on a daily basis. These tasks include:

- Laundry;
• Meal preparation and storage;

• Shopping;

NOTE: The recipient does not have to accompany the worker to the store.

• Light housekeeping tasks (vacuuming, mopping floors, cleaning bathroom and kitchen, making the bed). The worker should make sure that pathways are free from obstructions;

• Assistance with scheduling medical appointments when necessary;

• Accompanying the recipient to medical appointments when necessary;

NOTE: These medical appointments include, but are not limited to appointments for physician visits, physical therapy, occupational therapy, and speech therapy.

• Assisting the recipient with accessing transportation;

• Medication oversight – assistance with self-administration of prescription and non-prescription medication. This assistance is limited to:
  • verbal reminders;
  • assistance with opening the bottle or bubble pack;
  • reading the directions from the label;
  • checking the dosage according to the label directions; and/or
  • assistance with ordering medication from the drug store;

NOTE: The worker is not allowed to give medication to the recipient. This includes taking medicine out of a bottle to set up pill organizers.

• Medically non-complex tasks where the direct service worker (DSW) has received the proper training pursuant to Louisiana Revised Statutes 37:1031-1034.
NOTE: Emergency and non-emergency medical transportation is a covered Medicaid service and is available to all recipients. Non-medical transportation is not a required component of LT-PCS. However, providers may choose to furnish transportation for recipients during the course of providing LT-PCS. If transportation is furnished, the provider must accept all liability for their employee transporting a recipient. It is the responsibility of the provider to ensure that the employee has a current, valid driver’s license and automobile liability insurance.

Location of Service

LT-PCS must be provided in the recipient’s home or in another location outside of the recipient’s home if the provision of these services allows the recipient to participate in normal life activities as they pertain to the IADL cited in the plan of care (POC). Services that are provided in the recipient’s home must be provided while the recipient is present. The recipient's home is defined as the place where the recipient resides such as a house, apartment, a boarding house, or the house or apartment of a family member or unpaid primary caregiver.

NOTE: LT-PCS cannot be provided in a hospital, an institution for mental disease, a nursing facility, an adult day health care center or an intermediate care facility for individuals with an intellectual disability.

Services rendered outside of the recipient’s home do not include trips outside of the borders of the state without written prior approval from the Office of Aging and Adult Services (OAAS) or its designee, through the POC or otherwise. The recipient’s written request shall include a detailed explanation and must be sent to OAAS, or its designee, at least 24 hours prior to the anticipated travel, when applicable.

LT-PCS recipients are not permitted to receive LT-PCS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of LT-PCS, and providers are prohibited from providing and billing for services under these circumstances. Recipients may not live in the home of their DSW unless their direct service worker is related by blood or marriage to the recipient. (See link in Appendix D for further clarification.)

Service Limitations

LT-PCS are limited to no more service hours than those which are approved in the POC in any week.

For tasks that a recipient can complete without physical assistance or difficulty, assistance shall be limited to prompting or reminding the recipient to complete the task.
Minor children are not considered part of the informal supports available to a recipient.

There shall be no duplication of services. LT-PCS may not be provided while the recipient is admitted to or attending a program which provides in-home ADL or IADL assistance or while attending a program or setting where such assistance is available to the recipient. In cases where a recipient goes to the Emergency Room Department, the LT-PCS worker may provide assistance up until the time the recipient is admitted to the hospital.

Excluded Services

LT-PCS does not include:

- Insertion and sterile irrigation of catheters, although changing and emptying the catheter bag is allowed;
- Irrigation of any body cavities which require sterile procedures;
- Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate or severe skin problems;
- Skilled nursing services as defined in State Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;
- Teaching a family member or friend how to care for a recipient who requires assistance with ADL;
- Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;
- Specialized aide procedures such as rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services), measuring/recording patient vital signs (temperature, pulse, respiration and/or blood pressure, etc.) or intake/output of fluids, specimen collection, or special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercise, weight measurement, or enemas;
- Administration of medication;
Rehabilitative services such as those performed by an occupational therapist, speech therapist, audiologist or respiratory therapist;

Laundry, other than that incidental to the care of the recipient. Example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the recipient’s clothing or bedding;

Food preparation or shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient, and not for items used by the rest of the household;

Housekeeping in areas of the house not used by the recipient;

Companionship; or

Continuous or intermittent supervision.

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

LT-PCS and Hospice

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

The hospice provider must provide all hospice services as defined in 42CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling. Once the hospice program requirements are met, LT-PCS can be utilized for those personal care tasks covered in the LT-PCS program for which the recipient requires assistance.
Shared LT-PCS

LT-PCS may be provided by one DSW for up to three recipients with LT-PCS being provided as part of their Adult Day Health Care (ADHC) Waiver Services. The ADHC LT-PCS recipients must:

- Live together; and
- Have a common direct service provider.

Sharing of the DSW must be agreed upon by each recipient and only when the health and welfare of each recipient can be reasonably assured. Shared LT-PCS must be identified in the approved POC for each recipient. Reimbursement rates are adjusted accordingly. Recipients who choose to share services must agree to sign a confidentiality consent form to facilitate the coordination of services. (See Appendix D for information on accessing this form.)
RECIPIENT REQUIREMENTS

LT-PCS are available to recipients who meet the following criteria. The recipient:

- Is age 65 years or older, or 21 years of age or older with a disability. Disabled is defined as meeting the disability criteria established by the Social Security Administration;

- Meets the medical standards for admission to a nursing facility as presumptively determined by the Level of Care Eligibility Tool (LOCET) and verified by the Minimum Data Set – Home Care (MDS-HC);

- Is at imminent risk of nursing facility placement, which means that a person faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than 120 days. This criterion is considered met if the recipient:
  - Is in a nursing facility and could be discharged if community-based services were available;
  - Is likely to require nursing facility admission within the next 120 days as determined by the LOCET and MDS-HC; or
  - Has a primary caregiver who has a disability or is age 70 or older;

- Requires at least limited assistance (as defined by the MDS-HC) with one or more ADL. The MDS-HC defines Limited Assistance for most ADL as the receipt of physical help or a combination of physical help and weight-bearing assistance at specified frequencies during the period just prior to the MDS-HC assessment; and

- Is able to participate in his/her care and self-direct the services of the worker independently or through a responsible representative.

Responsible Representative

A responsible representative is defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining LT-PCS.
A responsible representative may not represent more than two recipients in any Office of Aging and Adult Services (OAAS)-operated Medicaid home and community-based service program at the same time. This includes but is not limited to the following programs:

- Program of All-Inclusive Care for the Elderly (PACE),
- LT-PCS,
- Community Choices Waiver, and
- Adult Day Health Care Waiver.
RECIPIENT RIGHTS AND RESPONSIBILITIES

Rights

Recipients of personal care services have the following rights:

- To be treated with dignity and respect;
- To receive services according to the approved Plan of Care;
- To have freedom of choice in the selection of a provider;
- To change providers after every 3 months without good cause or any time with good cause;
- To actively participate in the development of the Plan of Care;
- To actively participate in the decision-making process regarding service delivery; and
- To have an informal resolution process to address complaints and/or concerns regarding LT-PCS.

Responsibilities

Recipients and personal representatives have the following responsibilities to cooperate with the selected agency in the delivery of services by:

- Being available to receive scheduled services;
- Contacting the agency to cancel a scheduled visit;
- Being courteous and respectful to the worker; and
- Maintaining a safe and lawful environment.

Changing Providers

A recipient may change providers without good cause once after every 3 months of service. A recipient may request to change providers with good cause at any time during the service
authorization period. Good cause is defined as the failure of the provider to furnish services in compliance with the Plan of Care. Good cause shall be determined by OAAS or its designee. All requests for change of provider shall be submitted in writing to the access contractor. Providers will receive written notification when approval has been given for recipients to change providers.
SERVICE AUTHORIZATION PROCESS

Recipients who have been presumptively determined to meet nursing facility level of care and imminent risk requirements by the Level of Care Eligibility Tool (LOCET) will have a Minimum Data Set-Home Care (MDS-HC) assessment performed by the Office of Aging and Adult Services (OAAS) or its designee. The assessment and any other documentation are reviewed to determine if the recipient meets nursing facility level of care and qualifies for other program requirements. The Plan of Care is developed based on the results of the MDS-HC.

Provider Selection

If approved for services, an approval notice is sent to the recipient with a copy of the Plan of Care, a list of enrolled Medicaid long term-personal care services (LT-PCS) agencies that provide services in his/her area, and an Agreement to Provide Services form. The recipient is instructed to select and contact a provider to arrange for services. Providers will need to meet with the recipient to review the Plan of Care and discuss provision of the services.

If the provider agrees to provide the services, the contractor should be contacted and the appropriate documentation must be sent to them within 14 calendar days. (Refer to Appendix F for contractor information)

If the chosen provider declines to serve an individual, the provider must furnish to the entity that developed the Plan of Care written documentation that supports an inability to meet the individual’s health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The individual will then be asked to choose another provider.

Prior Authorization

All services for LT-PCS must be prior authorized. It is the responsibility of the provider to verify current prior authorizations (PAs) before services begin for a recipient. Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

A PA number is assigned, and approved units of service are released on a weekly basis to the provider. The approved units of service must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For prior authorization purposes, a week is defined as beginning midnight Sunday and ending midnight Saturday.
A PA number will be issued to providers for the service authorization period, unless the recipient changes providers. Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

All requests for changes in services and/or service hours must be made by the recipient or his/her responsible representative. A status change assessment will be performed for all requests where a change in the recipient’s level of functioning is reported. The status change assessment may be done by telephone or in person, at the discretion of OAAS or its designee.

Reassessments will be conducted at least once every 18 months to determine ongoing qualification for services.
PROVIDER REQUIREMENTS

Standards of Participation

In order to participate as a personal care services provider in the Medicaid Program, a provider must:

- Comply with:
  - State licensing regulations;
  - Medicaid provider enrollment requirements;
  - The standards of care set forth by the Louisiana Board of Nursing; and
  - Any federal or state laws, rules, regulations, policies and procedures contained in this provider manual or other document issued by the Louisiana Department of Health (LDH); and

- Possess a current, valid home and community-based services license to provide personal care attendant services that has been issued by the LDH Health Standards Section.

A Medicaid enrolled provider must:

- Maintain adequate documentation as specified by the Office of Aging and Adult Services (OAAS), or its designee, to support service delivery and compliance with the approved plan of care and provide said documentation at the request of LDH, or its designee; and

- Assure that all agency staff is employed in accordance with Internal Revenue Service and Department of Labor regulations.

**Providers are not to employ individuals who have been convicted of child or client abuse, neglect or mistreatment, or who have a felony involving physical harm to an individual.**

Providers must document that criminal record history checks have been obtained on all employees and employees of subcontractors, and that all reasonable steps were made to determine whether applicants for employment have histories indicating involvement in child or client abuse, neglect or mistreatment, or have a criminal record involving physical harm to an individual. Failure to comply with these regulations may result in any or all of the following:
Providers shall not refuse to serve any recipient who chooses their agency, unless there is documentation to support an inability to meet the recipient’s needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. OAAS, or its designee, must be notified immediately of the circumstances surrounding the refusal. The refusal request must be made in writing by the provider to OAAS, or its designee, and to the recipient detailing why the provider is unable to serve the recipient. This requirement can only be waived by OAAS or its designee.

Involuntary transfer or discharge of a recipient must be made in accordance with licensing standards.

Providers shall not interfere with the eligibility, assessment, care plan development or care plan monitoring processes. This includes, but is not limited to, coercing, harassing, intimidating or threatening the recipient or members of the recipient’s informal network, OAAS’ designated contractor staff or employees of LDH.

OAAS, or its designee, is charged with the responsibility of setting the standards, monitoring the outcomes and applying administrative sanctions for failures by service providers to meet the minimum standards for participation. Failure to meet the minimum standards shall result in a range of required corrective actions including, but not limited to, the following:

- Removal from the Freedom of Choice listing;
- A citation of deficient practice;
- A request for corrective action plan; and/or
- Administrative sanctions.

Continued failure to meet the minimum standards shall result in the loss of referral of new Long-Term Personal Care Services (LT-PCS) recipients and/or continued enrollment as an LT-PCS provider.
Worker Qualifications

All staff providing direct care to the recipient must meet the qualifications for furnishing personal care services per the licensing regulations. The LT-PCS worker should demonstrate the following:

- Empathy toward the elderly and persons with disabilities;
- An ability to provide personal care services to the recipient as outlined in Sections 30.2 and 30.14 of this manual chapter; and
- The maturity and ability to deal effectively with the demands of the job.

The following individuals are prohibited from being reimbursed through the Medicaid LT-PCS Program for providing services to a recipient:

- The recipient’s spouse;
- The recipient’s curator;
- The recipient’s tutor;
- The recipient’s legal guardian;
- The recipient’s designated responsible representative; or
- The person to whom the recipient has given representative and mandate authority (also known as “power of attorney”).

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

Plan of Care

The plan of care (POC) identifies the recipient’s physical dependency needs that are covered in the Long-Term Personal Care Services (LT-PCS) program. The Office of Aging and Adult Services (OAAS) or its designee will develop the POC to correlate with the needs identified in the in-home assessment. The POC will describe each routine or task/activity listed including:

- The specific activities of daily living (ADLs) and instrumental activities of daily living (IADLs) tasks in which the individual requires assistance and how the LT-PCS worker is to perform the task (e.g. assist or cue the recipient), and

- The frequency of service for each routine and activity, including:
  - The number of days per week each routine or activity will be accomplished; and
  - The preferred time of day to accomplish the routine or activity when the time is pertinent, such as when to prepare meals.

This POC will be sent to the chosen provider for implementation.

Service Delivery and Plan of Care Revisions

Weekly units of service should be delivered in accordance with the POC and should not be more than the units specified in the POC. Where service delivery significantly differs from the POC, the worker should document the reason for the deviation on the service log and describe the reason(s)/justification(s), e.g., services were not provided because recipient refused services.

Under no circumstances may LT-PCS units (hours) be “banked,” “borrowed” or “saved” from one week to the next. Service must be given in the week for which it was intended, based upon the POC. Recipients have the flexibility to use the weekly LT-PCS units (hours) according to their preferences and personal schedule within the prior authorized week.

NOTE: A prior authorized week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. the following Saturday.

Even though the recipient’s POC shows an amount of time per task/activity, LT-PCS approvals are not based on the time per task/activity; however, the system still captures this data in this format.
Following the identified time per task/activity is not a requirement and it is not necessary to document any deviation from the time per task/activity. **The focus is on documenting that the task/activity required in the POC is actually performed.** (See Section 30.8 - Record Keeping for details on completing the service log.)

During brief periods (less than 30 calendar days duration), the provider may deviate from the POC. A description of the extenuating circumstances requiring a temporary deviation from the POC must be clearly documented in the LT-PCS Service Log, and the service log must reflect the services that were actually performed.

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

**Back-up Plan**

Providers must have a written back-up plan to provide services if the primary worker is unable to report to work. This plan must include a toll-free telephone number with 24 hour availability manned by an answering service that allows the recipient to contact the provider if the worker fails to show up for work. Providers must also have a pool of on-call or substitute workers available to ensure that services to the recipient will not be interrupted. On call or substitute workers must meet the same qualifications as the regular LT-PCS workers before they can provide services to the recipient.

This policy governing back-up plans must be made available to recipients and/or their personal representative when the Agreement to Provide Services form is being completed.

**Interruption of Services**

A recipient may have his/her services interrupted for a period not to exceed 30 calendar days without his/her services being terminated by the provider agency.

Services may be interrupted for the following circumstances:

- A hospital admission; or
- A temporary stay outside the home (e.g., a vacation).

Reimbursement is not available during service interruption periods.
Discontinuation of Services

A provider must provide written notification to the recipient or the responsible representative when discontinuing services for good cause. This notice must be written and delivered in accordance with all LDH rules. The notice must be sent at least 30 calendar days before the date on which the services are to be discontinued, should address the reason for discontinuation and include an explanation of appeal rights for the recipient.

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

- Upon the recipient’s request;
- If the recipient’s hospitalization is expected to last more than 30 calendar days, the provider may terminate services because of the unavailability of the recipient to receive services. When the recipient is discharged and returns home, he/she may choose the provider or another provider to continue receipt of services;
- Unsafe working conditions prevent the worker from performing his/her duties or threaten the worker’s personal safety (e.g., unsanitary conditions, illegal activities in the home, etc.). The provider must make a documented, reasonable effort to notify the recipient and/or the personal representative of the unsafe working conditions in the home and attempt to resolve the problem. At the same time, OAAS, or its designee, should be notified of the provider’s concerns for staff’s safety;
- The recipient no longer meets the Medicaid financial eligibility criteria;
- The recipient no longer meets the program requirements for LT-PCS;
- The recipient is incarcerated or placed under the supervision of the judicial system;
- The recipient is admitted to a long-term care facility; or
- The recipient moves out of the service area (permanently or for a period over 30 calendar days).

If services are discontinued, the provider must notify the access contractor within 24 hours. (See Appendix F for contact information.)
Providers should refer to the Medicaid Services Manual, Chapter 1 General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping. http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf.

Components of Record Keeping

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

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

Retention of Records

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

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

Confidentiality and Protection of Records

Records, including administrative and recipient, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use. Providers and their employees must not directly or indirectly disclose or knowingly permit the disclosure of any information concerning the agency, the recipients or their families to any unauthorized person. The provider must
safeguard the confidentiality of any information which may identify the recipient or his/her family. Confidential information shall only be released under the following conditions:

- Court order;
- Recipient’s written informed consent for release of information;
- Written consent of the individual to whom the recipient’s rights have been devolved when the recipient has been declared legally incompetent; or
- Compliance with the Federal Law, Confidentiality of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

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

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

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

**NOTE: Under no circumstances should providers allow staff to remove recipient records from the office.**

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

Recipient records must be located at the enrolled site.
Review by State and Federal Agencies

Providers must make recipient and personnel records available to LDH its designee, and/or other state and federal agencies within the specified timeframe given by LDH or its designee. The provider shall be responsible for incurring the cost of copying records.

Recipient Records

Providers must have a separate written record for each recipient served by the provider. It is the responsibility of the service provider to accurately document services thereby conveying an ongoing chronology of activities/services provided to the recipient. Services provided must clearly be related to the services documented in the recipient’s plan of care (POC).

Records at the Recipient’s Home

Providers must maintain the following documents at the recipient’s home:

- A current copy of the recipient’s POC and POC revision (if applicable); and
- Copies of the recipient’s service logs for the current prior authorized week. (A prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Saturday at 11:59 p.m.).

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

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

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

Organization of Records, Record Entries and Corrections

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

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

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

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

Service Logs

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

Service logs contain the following information:

- Name of recipient;
- Name of provider and employee providing the service;
- Date of service contact; and
- Content of service contact.

NOTE: The start and stop time of service contacts, as well as the location where check in/check out occurs, are captured through the use of an Electronic Visit Verification (EVV) System.
A separate service log must be kept for each recipient. Reimbursement is only payable for services documented in the service log. Providers are required to use the LT-PCS log issued by OAAS. (See Appendix D for information on accessing this form and the associated instructions.)

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

Service logs must be:

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

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

- Observed changes in the recipient's mental and/or medical condition(s), behavior or home situation that may indicate a need for a reassessment and POC, and/or ISP change (as applicable);
- Any **SIGNIFICANT DEVIATIONS** from the POC; and
- Other information important to ensure continuity of care.

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

- Provided more assistance than what is indicated in the POC due to the recipient’s request or his/her increased need;
- Assistance not provided with a particular task/subtask as indicated in the POC due to recipient’s request or his/her lack of need;
- Significant deviation from the POC’s flexible scheduled arrival/departure time and/or days on which services are provided.

**NOTE:** Arriving or departing within 15 minutes of the flexible schedule’s time due to everyday factors (e.g. traffic, etc.) is NOT considered a significant deviation from
the POC AS LONG AS services are still provided at the same amount, frequency and duration as indicated in the POC.

If a recipient, for any reason, did not use all or part of his/her LT-PCS hours on a particular day but the unused LT-PCS hours were used in other days throughout that week, it MUST be clearly documented how the hours were used and the justification or need for the hours on that day. When hours are not used, they CANNOT be used later in the week just to “make up” the hours; therefore, workers CANNOT do the same task/activity twice in one (1) day just to “make up” the unused hours. There MUST be an ACTUAL need for the unused hours on the day that they are actually used.

When progress notes are written, they must:

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

Each provider’s documentation should support justification for prior authorization or payment of services. Services billed must clearly be related to the current approved POC and Individualized Service Plan (ISP), if applicable.

**Transfers and Closures**

A progress note MUST be entered in the recipient's record when a case is transferred or closed.

A discharge summary must also be entered in the recipient’s record and detail the recipient’s progress prior to a transfer or closure. This summary must be completed within 14 calendar days following a recipient’s discharge.
INCIDENTS, ACCIDENTS AND COMPLAINTS

LT-PCS staff must report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion to the on-duty supervisor immediately and as mandated by law to the appropriate agency named below. Only reporting to a supervisor does not satisfy the legal requirement to report. The supervisor shall be responsible for ensuring that a report or referral is made to the appropriate agency.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of all incidents and accidents involving the recipient that occurred during the course of delivering services. The Incident/Accident report shall be maintained in the recipient’s record. The report shall include:

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

Imminent Danger and Serious Harm

Providers must report all suspected cases of abuse (physical, mental, and/or sexual), neglect, exploitation or extortion to Adult Protect Services (APS). APS investigates and arranges for services to protect disabled and elderly adults at risk of abuse, neglect, exploitation or extortion. In addition, any other circumstance that place the recipient’s health and well-being at risk should be reported. (See Appendix F for contact information)

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

Internal Complaint Policy

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

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

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

- The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint within five working days.

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

- The provider must inform the recipient, the complainant, and/or the responsible representative in writing within ten working days of receipt of the complaint, the results of the internal investigation.

- If the recipient is dissatisfied with the results of the internal investigation, he/she may continue the complaint resolution process by contacting OAAS in writing within thirty calendar days of the date of the complaint resolution letter at:

  Office of Aging and Adult Services  
  P.O. Box 2031  
  Baton Rouge, LA 70821-2031  
  Attn: Quality Assurance Section

OAAS will notify the complainant within ten working days that the complaint has been received and is being investigated.
REIMBURSEMENT

All claims for LT-PCS shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. Providers must utilize the HIPAA compliant billing procedure code and modifier. Refer to Appendix E for information about procedure code, unit of service and current reimbursement rate.

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

Services to Multiple Recipients in the Same Home by the Same Provider

Providers who provide services to more than one recipient in the same household must bill separately for each recipient based on his/her Plan of Care.
FRAUD AND ABUSE

General

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

Fraud

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

Provider Fraud

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

- Billing for services that are not rendered to, or used for, Medicaid recipients;
- Claiming costs for non-covered or non-chargeable services disguised as covered items;
- Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the recipient of the services;
- Submitting duplicate billing to the Medicaid Program or to the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and
- Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid.
Recipient Fraud

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

- The misrepresentation of facts in order to become or to remain eligible to receive benefits under the Louisiana Medicaid Program or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;

- The transferring (by a recipient) of a Medicaid Eligibility Card to a person not eligible to receive services under the Louisiana Medicaid Program or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and

- The unauthorized use of a Medical Eligibility Card by persons not eligible to receive medical benefits under Medicaid.
RESERVED

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EPSDT - PCS OVERVIEW

The Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) established a program that may provide Personal Care Services (PCS) to eligibles (recipients up to age 21 years) meeting the medically necessary criteria for these services. The services offered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) PCS program are provided by a Medicaid enrolled agency that has a valid Personal Care Attendant License issued by the DHH.

The EPSDT – PCS program, by definition, does not include any medical tasks such as medication administration, tracheotomy care, feeding tubes, or catheters. If such tasks are necessary, they must be requested under either the Home Health Program or, if the recipient is certified for home and community based waiver services, through the waiver program. BHSF will not accept the physician’s delegation for EPSDT – PCS providers to perform such medical tasks.
EPSDT – PCS COVERED SERVICES

Personal care services are defined as tasks that are medically necessary as they pertain to an EPSDT eligible's physical requirements when physical limitations due to illness or injury necessitate assistance with eating, bathing, dressing, personal hygiene, bladder or bowel requirements, and these services prevent institutionalization and enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

Service Definitions

EPSDT – Personal Care Services include the following tasks:

- Basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with clothing,
- Assistance with bladder and/or bowel requirements or problems, including helping the recipient to and from the bathroom or assisting the recipient with bedpan routines, but excluding catheterization.
- Assistance with eating and food, nutrition and diet activities, including preparation of meals for the recipient only.
- Performance of incidental household services, only for the recipient, not the entire household, which are essential to the recipient’s health and comfort in his/her home. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the recipient.

Examples of such activities are:

- Changing and washing the recipient’s soiled bed linens.
- Rearranging furniture to enable the recipient to move about more easily in his/her own home.
- Cleaning the recipient’s eating area after completion of the meal and/or cleaning items used in preparing the meal, for the recipient only.
- Accompanying, not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services.
EPSDT – PCS are not to be provided to meet child care needs nor as a substitute for the parent in the absence of the parent.

EPSDT – PCS are not allowable for the purpose of providing respite care for the primary care giver. Respite services are only available through the home and community based waiver programs.

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

Location of Service

EPSDT personal care services must be provided in the recipient’s home or in another location outside the recipient’s home, if it is medically necessary to be outside of the recipient’s home. The recipient’s home is defined as the recipient’s own dwelling: an apartment, a custodial relative’s home, a boarding home, a foster home, a substitute family home or a supervised living facility.

Institutions such as a hospital, institution for mental diseases, nursing facility, intermediate care facility for the developmentally disabled or residential treatment center are not considered a recipient’s home.

Service Limitations

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

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

Excluded Services

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

- Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed),
- Irrigation of any body cavities which require sterile procedures,
• Application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate or severe skin problems,

• Administration of injections of fluid into veins, muscles or skin,

• Administration of medicine (as opposed to assisting with self-administered medication for EPSDT eligibles over eighteen years of age),

• Cleaning of floor and furniture in an area not occupied by only the recipient,

Example: Cleaning entire living area if the recipient occupies only one room or an area shared with other household members,

• Laundry, other than that incidental to the care of the recipient,

Example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the recipient’s clothing or bedding,

• Shopping for groceries or household items other than items required specifically for the health and maintenance of the recipient, and not for items used by the rest of the household,

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

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

• Specialized nursing procedures such as:
  • Insertion of nasogastric feeding tube
  • In-dwelling catheter
  • Tracheotomy care
  • Colostomy care
  • Ileostomy care
  • Venipuncture
  • Injections
- Rehabilitative services such as those administered by a physical therapist,

- Teaching a family member or friend techniques for providing specific care,

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

- Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process,

- Specialized aide procedures such as:
  - Rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services)
  - Measuring/recording patient vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids
  - Specimen collection
  - Special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas

- Home IV therapy,

- Custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task,

- Occupational therapy,

- Speech pathology services,

- Audiology services,

- Respiratory therapy,

- Personal comfort items,

- Durable medical equipment,

- Oxygen,
• Orthotic appliances or prosthetic devices,
• Drugs provided through the Louisiana Medicaid pharmacy program,
• Laboratory services, and
• Social work visits,
RECIPIENT CRITERIA

Conditions for provisions of EPSDT – Personal Care Services (PCS) are as follows:

- **Medicaid Eligibility**

  The person must be a categorically eligible Medicaid recipient birth through 20 years of age (EPSDT eligible) and have been prescribed EPSDT – PCS as medically necessary by a physician. The physician shall specify the health/medical condition which necessitates EPSDT – Personal Care Services.

- **Medical Necessity**

  An EPSDT eligible must meet medical necessity criteria as established by the Bureau of Health Services Financing (BHSF) which shall be based on criteria equivalent to at least an Intermediate Care Facility 1 (ICF-1) level of care; and be impaired in at least two activities of daily living tasks, as determined by BHSF.

  To establish medical necessity, the parent or guardian must be physically unable to provide personal care services to the child.

  If the parent(s) is in the home and is not providing care to the EPSDT eligible, medical documentation for the parent or guardian must be submitted with the request so that BHSF may determine that the parent(s) is physically unable to provide personal care services to the child.

  To establish medical necessity, the EPSDT eligible must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.

- **Available Supports**

  When determining whether a recipient qualifies for EPSDT – PCS, consideration must be given not only to the type of services needed, but also the availability of family members and/or friends who can aid in providing such care. EPSDT – PCS are not to function as a substitute for child care arrangements.

- **Physician Referral**

  EPSDT – PCS must be prescribed by the recipient’s attending physician initially and every 180 days after that (or rolling six months), and when changes in the Plan of Care occur.
The Plan of Care shall be acceptable for submission to BHSF only after the physician signs and dates the form.

The physician’s signature must be an original signature and not a rubber stamp.
EPSDT – PCS RIGHTS AND RESPONSIBILITIES

The recipient shall be allowed the freedom of choice to select an EPSDT – PCS provider. This freedom also extends to the recipient’s right to change providers at any time should he or she finds it necessary to cease the relationship with the current provider.

Recipients may contact the Bureau of Health Services Financing directly for assistance in locating an EPSDT – PCS provider to submit a prior authorization request for medically necessary personal care services. (See Appendix H for contact information.)
EPSDT – PCS PRIOR AUTHORIZATION

EPSDT – personal care services must be prior authorized by the BHSF or its designee. Services shall not be authorized for more than a six month period. A face-to-face medical assessment must be completed by the physician. The recipient’s choice of a personal care services provider may assist the physician in developing a plan of care which shall be submitted for review/approval by BHSF or its designee. Recipients may contact the BHSF directly for assistance in locating a provider to submit a prior authorization request for medically necessary personal care services. (See Appendix H for contact information.)

Initial and Subsequent Prior Authorization Requests

All initial and subsequent prior authorization requests for EPSDT – PCS must be accompanied by the following documents:

- Copy of the recipient’s Medicaid Eligibility Card,
- Physician’s referral for PCS,
- EPSDT – PCS must be prescribed by the recipient’s attending physician initially and every 180 days after that (or rolling six months), and when changes in the Plan of Care occur. The prescription does not have to specify the number of hours being requested, but must specify PCS and not PCA.
- The physician’s signature must be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted.
- Signatures by nurse practitioners and registered nurses on the referrals are not acceptable.
- Plan of Care prepared by the PCA agency with physician approval,
- The provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF.
- EPSDT – PCS Form 90,
- Completed by the attending physician,
- Completed within the last 90 days,
- Documents the recipient requires/would require institutional level of care equal to an Intermediate Care Facility 1,
• Documents a face-to-face medical assessment was completed.

• EPSDT – PCS Daily Schedule Form,

• EPSDT Personal Care Services - Social Assessment Form,

  • Specifies the personal care activities which the parent or other caregiver is providing and requires assistance with, and
  • States the reason the parent cannot provide the assistance.

• Request for Prior Authorization Form (PA-14), and

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

**NOTE:** Information about forms used with a prior authorization request can be found in Appendix I.

Requests for prior approval of EPSDT – Personal Care Services should be submitted by mail, by fax or electronically (e-PA) to the Prior Authorization Unit. (See Appendix H for contact information.)

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

**Chronic Needs Case**

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

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

**NOTE:** Only DHH or its designee will be allowed to grant the designation of a “chronic needs case” to a recipient.
Plan of Care

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

Dates of care not included in the Plan of Care or services provided before approval of the Plan of Care by BHSF are not reimbursable.

The recipient’s attending physician shall review and/or modify the Plan of Care and sign and date it prior to the Plan of Care being submitted to BHSF.

The Plan of Care shall include the following information:

- Recipient name, Medicaid ID number, date of birth and address, phone number,
- Date EPSDT personal care services are requested to start,
- Provider name, Medicaid provider number and address of personal care agency,
- Name and phone number of someone from the provider agency that may be contacted, if necessary for additional information,
- Medical reasons supporting the need for PCS (must be accompanied by appropriate medical documentation for recipient and parent/caregiver, if parent/caregiver is disabled),
- Other in-home services the recipient is receiving,
- Specific personal care tasks (bathing, dressing, eating, etc.) with which PCS provider is to assist the recipient,
- Goals for each activity,
- Number of days services are required each week,
- Time requested to complete each activity,
- Total time requested to complete each activity each week,
Child care arrangements specified for children 14 years of age or younger, (parent/relative/paid caregiver), and

Signature of parent/primary caregiver, provider representative and the recipient’s primary physician.

Changes in Plan of Care

Amendments or changes in the Plan of Care should be submitted as they occur and shall be treated as a new Plan of Care which begins a new six-month service period. Revisions of the Plan of Care may be necessary because of changes that occur in the recipient’s medical condition which warrant an additional type of service, an increase or decrease in frequency of service or an increase or decrease in duration of service.

Documentation for a revised Plan of Care is the same as for a new Plan of Care. Both a new “start date” and “reassessment date” must be established at the time of reassessment. The provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF.

Subsequent Plans of Care

A new Plan of Care must be submitted at least every 180 days (rolling six months). The subsequent Plan of Care must:

- Be approved by the recipient’s attending physician,
- Reassess the recipient’s need for EPSDT – PCS,
- Include any updates to information which has changed since the previous assessment was conducted, and
- Explain when and why the change(s) occurred.

The physician shall only sign and date a fully completed Plan of Care that is acceptable for submission to BHSF.

The physician’s signature must be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted.
Reconsideration Requests

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

- A copy of the prior authorization notice with the word “Recon” written across the top and include the reason the reconsideration is being requested written across the bottom,
- All original documentation submitted from the original request, and
- Any additional information or documentation which supports medical necessity.

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

Changing PCS Providers

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

NOTE: Recipients may contact the Bureau of Health Services Financing directly for assistance in locating another provider.

Prior Authorization Liaison

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

Standards of Participation

Personal care services must be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. Agencies providing EPSDT – PCS shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by federal, state and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, Occupational Safety and Health Administration requirements, liability insurance, Worker’s Compensation, occupational licenses, etc. Agencies shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

EPSDT – PCS may be provided only to EPSDT eligibles and only by a staff member of a licensed Personal Care Attendant (PCA) agency enrolled as a Medicaid personal care services provider.

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

Additional copies of current licenses shall be submitted to Provider Enrollment thereafter as they are issued for inclusion in the enrollment record. The provider’s enrollment record must include a current PCA license at all times.

Enrollment is limited to providers in Louisiana and out-of-state providers only in trade areas of states bordering Louisiana (Arkansas, Mississippi, and Texas).

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

Staffing

The PCS agency is responsible for ensuring that all individuals providing personal care services meet all training requirements applicable under state law and regulations. Individuals who provide coverage in the PCS worker’s absence must meet all staffing requirements for the PCS worker or supervisor.

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

Staff assigned to provide personal care services shall not be a member of the recipient’s immediate family. (Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient.) Personal care services may be provided by a person of a degree of relationship to the recipient other than immediate family, if the relative is not living in the recipient’s home, or, if he/she is living in the recipient’s home solely because his/her presence in the home is necessitated by the amount of care required by the recipient.
EPSDT – PCS SERVICE DELIVERY

EPSDT – PCS providers may provide Children’s Choice waiver services to the recipient on the same date as PCS; however, both Children’s Choice waiver services and PCS may not be performed at the same time. If the recipient is receiving home health, respite, and/or any other related service, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider. PCS recipients may not receive hospice services while receiving PCS.
EPSDT – PCS RECORD KEEPING

Providers must maintain case records for all EPSDT – PCS recipients and personnel records on all supervisory and direct care staff. Records must be complete, accurately documented, readily accessible, and organized. All records must be retained for a period of five years. Billing records must be maintained for a period of five years from the date of payment.

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

There must be a clear audit trail between:

- The prescribing physician,
- The personal care services provider agency,
- The person providing the personal care services to the recipient, and
- The services provided and reimbursed by Medicaid.

Recipient Records

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

- Copies of all Plans of Care, Social Assessments, EPSDT PCS Form 90, EPSDT – PCS Daily Schedule Forms and Physician’s Order/Prescription for EPSDT Personal Care Services,
- Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying the Plan of Care including the tests performed and results, copies of evaluation and diagnostic assessment reports signed by the individual performing the test and/or interpreting the results,
- Documentation of approval of services by BHSF or its designee, and
- Documentation of the provision of services by the Personal Care Services worker including signed daily notes by the worker, and supervisor if appropriate, that include:
CHAPTER 30: PERSONAL CARE SERVICES

SECTION 30.20: EPSDT – PCS RECORD KEEPING

- Date of service,
- Services provided (checklist is adequate),
- Total number of hours worked,
- Time period worked,
- Condition of recipient,
- Service provision difficulties,
- Justification for not providing scheduled services, and
- Any other pertinent information.

Availability of Records

Providers must make recipient and personnel records available to DHH, its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for DHH or its designee.
EPSDT – PCS REIMBURSEMENT

All claims for EPSDT – PCS shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. Providers must utilize the HIPAA compliant billing procedure code and modifier. Refer to Appendix E for information about procedure code, unit of service and the current reimbursement rate. EPSDT – PCS shall be paid the lesser of billed charges or the maximum unit rate set by BHSF.

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

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

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

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

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

Hardcopy claims must be mailed to the Fiscal Intermediary. (See Appendix H for contact information.)
PROVIDER NOTICE

Dear ________________,

This letter is to notify your agency of the following regarding Medicaid Long Term Personal Care Services (LT-PCS):

☐ We have been notified by the above named recipient that your agency was selected and has agreed to provide LT-PCS. Before services can be authorized, you must submit a signed Agreement to Provide Services. This information must be received within 14 days of the date of this notice to the following address/fax:

Xerox State Healthcare, LLC
2900 Westfork Drive
Suite 540
Baton Rouge, LA 70827
Fax: (866) 246-8511
Attn: Long Term-Personal Care Services

☐ We notified you on (date of notice of selection letter) that your agency was selected to provide LT-PCS to the above named recipient. As of this date, we have not received the required information as indicated below:

☐ A signed copy of your Agreement to Provide Services.

Since we have been unsuccessful in reaching you by telephone, we are requesting that you contact our office by ______ to discuss this matter. Failure to contact this office may result in the recipient selecting another provider.
Provider Notice
Page 2

☐ We have been notified that the above named recipient wishes to change LT - PCS providers. Effective __________ your authorization to provide these services to this recipient will end.

NOTE: PRIOR AUTHORIZATION WILL BE EFFECTIVE THE DATE THE AGREEMENT TO PROVIDE SERVICE IS APPROVED. PAYMENT WILL NOT BE MADE FOR SERVICES PROVIDED PRIOR TO THE AUTHORIZATION DATE.

XEROX State Healthcare, LLC
Agency Representative

(877) 456-1146
Telephone Number
Agreement to Provide Services

Recipient Name: ______________________________  Date: ______________________________
Recipient Medicaid #: ________________________  Provider #: _________________________
Recipient SSN: _______________________________  Provider Name: _______________________
(Your Agency’s Provider Number)  (Your Company’s Name)

A representative from our agency met with ______________________________
(Recipient’s Name) on ______________________________ We have reviewed his/her Plan of Care that has been approved by
(Date of Meeting with Recipient) the Department of Health and Hospitals.

We agree to provide services to this recipient according to the:
☐ Initial Plan of Care dated
☐ Reassessment Plan of Care dated
☐ Status Change Plan of Care dated

We understand that Xerox State Healthcare, LLC will not be able to issue an authorization to our agency until they receive this form signed by both the recipient or their personal representative and our agency representative.

____________________________________  ______________________________
Recipient Signature  Date of Signature

____________________________________  ______________________________
Personal Representative Signature  Date of Signature

____________________________________  ______________________________
Provider Agency Representative Signature  Date of Signature

Long Term Care - Access Services
2900 Westbury Drive, Suite 540; Baton Rouge, LA 70837
Phone #: 877.486.1146 (TDD 866.298.0236) - Fax #: 866.246.8511

Re-issued 05/01/08

LT-PCS-17
Page 1 of 1
**APPENDIX C – LT-PCS PLAN OF CARE FORM**

### Identifying Information

Name:

ID No.:

Phone No.:

Address 1:

Address 2:

City:

State:

Zip:

Responsible Representative:

Representative's Phone No.:

### Household Composition

<table>
<thead>
<tr>
<th>Household Member</th>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>Parent</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>Spouse</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>Child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Always Work or School</th>
<th>0: None</th>
<th>1: Work</th>
<th>2: School</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Spouse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Child</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Always Work or School</th>
<th>0: None</th>
<th>1: Work</th>
<th>2: School</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Spouse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Child</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physical Health Status - Notes

### Medical Health Status - Notes

### Psychiatric Health Status - Notes

### Services Identified - Activities of Daily Living

<table>
<thead>
<tr>
<th>CODE</th>
<th>ADL Level</th>
<th>Current ADL Need</th>
<th>Level of ADL Need</th>
<th>Support</th>
<th>Type of Support</th>
<th>Schedule/ Frequency of Support</th>
<th>Time for Each Activity</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>ADL Level</th>
<th>Current ADL Need</th>
<th>Level of ADL Need</th>
<th>Support</th>
<th>Type of Support</th>
<th>Schedule/ Frequency of Support</th>
<th>Time for Each Activity</th>
</tr>
</thead>
</table>

### Printed: 7/27/2009 10:32:50 AM
### Appendix C – LT-PCS Plan of Care Form

#### Services Identified - Instrumental Activities of Daily Living

For each activity, identify the results of the MDS-HC and whether or not assistance is needed. Identify who currently provides the support with a brief description of the support being provided. If the need is not being met, describe the support being recommended and the frequency that support is needed. Refer to Daily Level of Service Guide for Time Allocation.

<table>
<thead>
<tr>
<th>CODES: MDS-HC Level</th>
<th>Needs Assistance</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 No Difficulty</td>
<td>0 None</td>
<td>0</td>
</tr>
<tr>
<td>1 Some Difficulty</td>
<td>1 Yes</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>2 Difficult</td>
<td></td>
<td>4, 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Level</th>
<th>Need</th>
<th>(Describe current support)</th>
<th>Type of Support Needed</th>
<th>Schedule/Frequency of Support</th>
<th>Time for Each Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Light Housekeeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Preparation and Storage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grocery Shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Reminders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance per Medical Appointment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Total Weekly Hours Recommended for ADLs

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix C – LT-PCS Plan of Care Form

#### Recommended Hours of Service

<table>
<thead>
<tr>
<th>1. Compute Weekly Hours</th>
<th>2. Compute Monthly Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLUS</td>
<td>MUST EXIST</td>
</tr>
<tr>
<td>EQUALS</td>
<td>4 units of service / hour</td>
</tr>
<tr>
<td>MULTIPLIED BY</td>
<td>EQUALS</td>
</tr>
<tr>
<td>Total weekly ADLs</td>
<td>Total monthly ADLs</td>
</tr>
<tr>
<td>Hrs</td>
<td>Hrs</td>
</tr>
<tr>
<td>Miss</td>
<td>Miss</td>
</tr>
</tbody>
</table>

#### Completed By

<table>
<thead>
<tr>
<th>Assessor info</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Completed by</td>
</tr>
<tr>
<td>b. Date</td>
</tr>
<tr>
<td>Month Day Year</td>
</tr>
</tbody>
</table>

#### Reviewed By

<table>
<thead>
<tr>
<th>QA Review info</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reviewed by</td>
</tr>
<tr>
<td>b. Date</td>
</tr>
<tr>
<td>Month Day Year</td>
</tr>
</tbody>
</table>

### This section is to be completed by DLTSS

1. Level of Service
   - The recipient’s medical condition meets nursing facility level of care
   - a. The recipient’s medical condition meets nursing facility level of care
     - b. No
     - c. Yes

2. Services Approved
   - a. DLTSS representative’s signature
     - b. Date
     - c. Month Day Year

3. Services Denied
   - a. DLTSS representative’s signature
     - b. Date
     - c. Month Day Year

4. Unable to Approve Packet
   - a. DLTSS representative’s signature
     - b. Date
     - c. Month Day Year
LT-PCS FORMS

The following forms and instructions are available on the Office of Aging and Adult Services’ website:

<table>
<thead>
<tr>
<th>Form/Document Name</th>
<th>Web Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term-Personal Care Services (LT-PCS)</td>
<td><a href="http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/LT-PCSServiceLogAndInstructions.pdf">http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/LT-PCSServiceLogAndInstructions.pdf</a></td>
</tr>
<tr>
<td>Weekly Services Log – Single Employee</td>
<td></td>
</tr>
<tr>
<td>or Long Term-Personal Care Services (LT-PCS)</td>
<td></td>
</tr>
<tr>
<td>Who Can Be A Direct Support Worker (DSW) for PAS &amp; LT-PCS?</td>
<td><a href="http://dhh.louisiana.gov/assets/docs/OAAS/Manuals/dswflowchart.pdf">http://dhh.louisiana.gov/assets/docs/OAAS/Manuals/dswflowchart.pdf</a></td>
</tr>
</tbody>
</table>
PERSONAL CARE SERVICES – BILLING INFORMATION

All personal care services must be prior authorized and billed using the appropriate provider number the agency was issued for personal care services.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Unit Size</th>
<th>Reimbursement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1019</td>
<td>EP</td>
<td>EPSDT – Personal Care Services</td>
<td>15 min</td>
<td>$2.53</td>
</tr>
<tr>
<td>T1019</td>
<td>UB</td>
<td>Long Term – Personal Care Services</td>
<td>15 min</td>
<td>$2.85</td>
</tr>
</tbody>
</table>
## LT-PCS CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Type of Assistance</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| XEROX (Access Contractor)                       | Office to send signed “Agreement to Provide Services” and who to contact when requesting LT-PCS | XEROX  
Long Term Care Access Services  
2900 Westfork Drive, Suite 540  
Baton Rouge, LA  70827  
Phone #: 877-456-1146  
TDD #: 877-544-9544  
Fax #: 866-246-8511 |
| OAAS State Office                               | Provides LT-PCS policy clarification and receives complaints regarding access contractor services | Office of Aging and Adult Services  
P. O. Box 2031  
Baton Rouge, LA  70821-2031  
Phone #: 866-758-5035 |
| Division of Administrative Law – Health and Hospitals Section | Office to contact to request an appeal hearing | Division of Administrative Law – Health and Hospitals Section  
P. O. Box 4189  
Baton Rouge, LA  70821-4189  
Phone #: (225) 342-0443  
Fax #: (225) 219-9823  
Oral appeals #: (225) 342-5800 |
| Health Standards Section                        | Office to contact when providers wish to request an informal hearing as the result of a monitoring corrective action report or to file a complaint against a provider agency | Dept. of Health and Hospitals Health Standards Section  
Attn: IDR Program Manager  
P. O. Box 3767  
Baton Rouge, LA  70821  
Phone #: 800-660-0488 |
| Adult/Elderly Protective Services                | Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of recipients | Phone #: 800-898-4910 |
ACRONYMS/DEFINITIONS

Abuse - The infliction of physical and mental injury on a recipient by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered.

Access Contractor – The contractor of a geographical area who is responsible for managing the authorization of services for recipients in the Long Term-Personal Care Services program.

Activities of Daily Living (ADL) - Those activities that are required by an individual for continued well-being, health and safety.

Agreement to Provide Services - An agreement between the provider of long term-personal care services and the recipient. The agreement specifies responsibilities with respect to the provision of services.

Appeal – A due process system ensuring a recipient an opportunity to contest certain decisions.

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

Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized plan of care.

Bureau of Health Services Financing (hereafter referred to as the Bureau) - The office within the DHH that is responsible for the administration of the Medicaid Program.

Certification Period – The time period that a Long Term-Personal Care Service recipient is qualified to receive services.

Chronic Needs Case – A designation granted to some EPSDT – Personal Care Service recipients by the Prior Authorization Unit when the recipient’s medical condition is such that services are expected to be continuous and remain at the level currently approved.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a recipient.

Department of Health and Hospitals (DHH) – The single state Medicaid agency for the state of Louisiana.

Early and Periodic Screening Diagnosis and Treatment (EPSDT) – Medicaid’s comprehensive and preventive child health program for individuals who are under the age of 21.
Fiscal Intermediary – The private fiscal agent contracted to operate the Medicaid Management Information System, which includes claims processing, issuing payments for services rendered and providing assistance to providers.

Good Cause – The failure of the long term-personal care service provider to furnish services in compliance with the plan of care. Good cause is determined by the Bureau or its designee.

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

Intake – The Long Term-Personal Care Service screening process consisting of activities necessary to determine the need and qualifications for personal care services.

Long Term-Personal Care Services (LT-PCS) – An optional service offered under the Louisiana Medicaid State Plan to provide assistance with the activities of daily living and instrumental activities of daily living to qualified Medicaid recipients.

Medicaid – A federal-state financed entitlement program operated under Title XIX of the Social Security Act which provides payment for medically necessary services rendered to eligible individuals.

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program.

Office of Aging and Adult Services (OAAS) – The office within the DHH responsible for the determination of level of care and review of plans of care for the Long Term-Personal Care Services Program.

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

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

Plan of Care – The written document that outlines how service will be delivered to a recipient. It should identify each service area and specify how and the recipient’s preference as to when the services will be executed by the personal care worker.

Provider – A licensed agency or individual furnishing personal care service under a provider agreement with the DHH.
Reassessment – The process utilized to review a recipient’s ongoing need and qualification for services. It provides the opportunity to gather information for reevaluating and revising the plan of care.

Recipient – An individual who has been determined to be eligible and receives Medicaid services.

Service Area – A designated region where services are provided.

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

Task List/Provider Agreement - An agreement between the long term-personal care service provider and the recipient. The document specifies the recipient’s preferences and the provider’s responsibilities with respect to the provision of services.

Waiver – An optional Medicaid program established under Section 1915 of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirements for an institutional level of care.
## EPSDT-PCS CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Common Questions</th>
<th>Who to Contact</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who can recipients call to request assistance in locating an EPSDT-PCS provider?</td>
<td>Bureau of Health Services Financing</td>
<td>1-888-758-2220</td>
</tr>
<tr>
<td>Where do providers send their prior authorization requests?</td>
<td>Molina – Prior Authorization Unit</td>
<td>Mail: Molina Medicaid Solutions P. O. Box 14919 Baton Rouge, La 70898-4919 Attn: Prior Authorization (PCS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: (225) 216-6342</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Electronic: <a href="http://www.lamedicaid.com">www.lamedicaid.com</a></td>
</tr>
<tr>
<td>Where do providers send their claims?</td>
<td>Molina Medicaid Solutions</td>
<td>Molina Medicaid Solutions P. O. Box 91020 Baton Rouge, LA</td>
</tr>
<tr>
<td>Who do providers contact regarding billing problems?</td>
<td>Molina Medicaid Solutions</td>
<td>1-800-473-2783 or (225) 924-5040</td>
</tr>
</tbody>
</table>
The following forms are used in the EPSDT Personal Care Services program and can be downloaded from www.lamedicaid.com at the “Forms/Files/User Manuals” link:

- Request for Prior Authorization (PA – 14)
- Request for Medicaid EPSDT – Personal Care Services (EPSDT PCS Form 90)
- EPSDT Personal Care Services – Plan of Care (EPSDT PCS POC – 1)
- EPSDT Personal Care Services – Social Assessment Form (EPSDT PCS Social Assessment – 2)
- EPSDT PCS Daily Schedule (EPSDT PCS Daily Schedule – 3)
CLAIMS FILING

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

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

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

Paper claims should be submitted to:

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

Services may be billed using:

- The rendering provider’s individual provider number as the billing provider number for independently practicing providers, or
- The group provider number as the billing provider number and the individual rendering provider number as the attending provider when the individual is working through a ‘group/clinic’ practice.

**NOTE:** Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid web site at [www.lamedicaid.com](http://www.lamedicaid.com), directory link “HIPAA Information Center, sub-link “5010v of the Electronic Transactions” – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
- Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.
### CMS 1500 (02/12) Billing Instructions for Personal Care Services

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung</td>
<td><strong>Required</strong> -- Enter an “X” in the box marked Medicaid (Medicaid #).</td>
<td></td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s I.D. Number</td>
<td><strong>Required</strong> – Enter the recipient’s 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. <strong>NOTE:</strong> The recipients’ 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is <strong>NOT</strong> acceptable. The ID number must match the recipient’s name in Block 2.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td><strong>Required</strong> – Enter the recipient’s last name, first name, middle initial.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td><strong>Required</strong> – Enter the recipient’s date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an “X” in the appropriate box to show the sex of the recipient.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td><strong>Situational</strong> – Complete correctly if the recipient has other insurance; otherwise, leave blank.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td><strong>Optional</strong> – Print the recipient’s permanent address.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td><strong>Situational</strong> – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is Patient’s Condition Related To:</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group or FECA Number</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Date of Birth Sex</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or Authorized Person’s Signature (Release of Records)</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Patient’s or Authorized Person’s Signature (Payment)</td>
<td>Situational – Obtain signature if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness / Injury / Pregnancy</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>OTHER DATE</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
<td>Optional.</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix J: Claims Filing

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>17a</td>
<td>Unlabeled</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab?</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>ICD Indicator</td>
<td>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.</td>
<td>The most specific diagnosis codes must be used. General codes are not acceptable. ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15. ICD-10 diagnosis codes must be used on claims for dates of service on or after 10/1/15. 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 (<a href="http://www.lamedicaid.com)">www.lamedicaid.com)</a></td>
</tr>
<tr>
<td></td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Required -- Enter the most current ICD diagnosis code.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NOTE: The ICD-9-CM &quot;E&quot; and &quot;M&quot; series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>22</td>
<td>Resubmission Code</td>
<td><strong>Situation</strong>al – If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the “Original Ref. No.” portion of this field. Appropriate reason codes follow:</td>
<td></td>
</tr>
</tbody>
</table>
|           |                               | **Adjustments**                                                             | - 01 = Third Party Liability Recovery  
- 02 = Provider Correction  
- 03 = Fiscal Agent Error  
- 90 = State Office Use Only – Recovery  
- 99 = Other       |
|           |                               | **Voids**                                                                   | - 10 = Claim Paid for Wrong Recipient  
- 11 = Claim Paid for Wrong Provider  
- 00 = Other       |
<p>| 23        | Prior Authorization (PA)      | <strong>Required</strong> – Enter the 9-digit prior authorization number for the authorized services. |                                                                                                                                                                                                       |
| 24        | Supplemental Information      | <strong>Situation</strong>al                                                               |                                                                                                                                                                                                       |
| 24A       | Date(s) of Service           | <strong>Required</strong> – Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable. |                                                                                                                                                                                                       |
| 24B       | Place of Service             | <strong>Required</strong> – Enter the appropriate place of service code for the services rendered. |                                                                                                                                                                                                       |
| 24C       | EMG                           | <strong>Leave Blank.</strong>                                                            |                                                                                                                                                                                                       |</p>
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
</table>
| 24D       | Procedures, Services, or Supplies | **Required** -- Enter the procedure code(s) for services rendered in the un-shaded area(s). Enter appropriate modifier with procedure code: 
**UB = LT-PCS**  
**EP = EPSDT-PCS** |        |
<p>| 24E       | Diagnosis Pointer                | <strong>Required</strong> -- Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number letter (&quot;A&quot;, &quot;B&quot;, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code. |        |
| 24F       | Amount Charged                   | <strong>Required</strong> -- Enter usual and customary charges for the service rendered.   |        |
| 24G       | Days or Units                    | <strong>Required</strong> -- Enter the number of units billed for the procedure code entered on the same line in 24D |        |
| 24H       | EPSDT Family Plan                | <strong>Situational</strong> -- Leave blank or enter a &quot;Y&quot; if services were performed as a result of an EPSDT referral. |        |
| 24I       | I.D. Qual.                       | <strong>Optional.</strong> If possible, leave blank for Louisiana Medicaid billing.       |        |
| 24J       | Rendering Provider I.D. #        | Leave Blank                                                                 |        |
| 25        | Federal Tax I.D. Number          | <strong>Optional.</strong>                                                               |        |
| 26        | Patient's Account No.            | <strong>Situational</strong> -- Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters. |        |
| 27        | Accept Assignment?               | <strong>Optional.</strong> Claim filing acknowledges acceptance of Medicaid assignment.   |        |
| 28        | Total Charge                     | <strong>Required</strong> -- Enter the total of all charges listed on the claim.          |        |
| 29        | Amount Paid                      | Leave Blank.                                                                |        |</p>
<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Reserved for NUCC use</td>
<td>Leave Blank.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier Including Degrees or Credentials Date</td>
<td>Optional – The practitioner or the practitioner’s authorized representative’s original signature is no longer required. Required -- Enter the date of the signature.</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information</td>
<td>Situational – Complete as appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>32a</td>
<td>NPI</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>32b</td>
<td>Unlabeled</td>
<td>Situational – Complete if appropriate or leave blank.</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info &amp; Phone #</td>
<td>Required -- Enter the provider name, address including zip code and telephone number.</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td>Optional.</td>
<td></td>
</tr>
<tr>
<td>33b</td>
<td>Unlabeled</td>
<td>Required – Enter the billing provider’s 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.</td>
<td>The 7-digit Medicaid Provider Number must appear on paper claims.</td>
</tr>
</tbody>
</table>

Sample forms are on the following pages.
PCS – Example Claim Form with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15)

<table>
<thead>
<tr>
<th>ITEM</th>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<td>4.</td>
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<td>5.</td>
<td></td>
<td></td>
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<td>6.</td>
<td></td>
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<td>7.</td>
<td></td>
<td></td>
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<tr>
<td>8.</td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td></td>
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<tr>
<td>16.</td>
<td></td>
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<td>17.</td>
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<td>18.</td>
<td></td>
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<td>19.</td>
<td></td>
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<td>20.</td>
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<td>21.</td>
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<td>22.</td>
<td></td>
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<tr>
<td>23.</td>
<td></td>
<td></td>
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<tr>
<td>24.</td>
<td></td>
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<td>25.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
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<td></td>
</tr>
<tr>
<td>28.</td>
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<tr>
<td>29.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN OR SUPPLIER INFORMATION**

<table>
<thead>
<tr>
<th>NAME</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NNUC BILLER**

<table>
<thead>
<tr>
<th>DATE</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/14</td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE PRINT OR TYPE**

<table>
<thead>
<tr>
<th>FORM</th>
<th>ANSI/3-1997 FORM CMS-1500 (02-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A VERY RELIABLE PCS AGENCY**

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 MAIN ST</td>
<td>(800) 222-3333</td>
</tr>
<tr>
<td>ANY TOWN, LA 70000</td>
<td></td>
</tr>
</tbody>
</table>

**NUCC Instruction Manual available at: www.nucc.org**
PCS – Example Claim Form with ICD-10 Diagnosis Code
(Dates ON OR AFTER 10/1/15)
Adjustments and Voids

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

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

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

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

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

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

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

- If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim.
- If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

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

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under Adjustment or Voided Claim. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.
The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column. When the void claim is approved, it will be listed under the "Void" column of the RA.

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

Sample forms are on the following pages.
The document is a PCA – Example Adjustment Form with ICD-9 Diagnosis Code (Dates BEFORE 10/1/15). It contains a claim form with various fields such as patient information, diagnosis, procedures performed, and financial details. The table below provides a sample of the information that might be filled in this form:

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Number</td>
<td>1234567891234</td>
</tr>
<tr>
<td>Patient Name</td>
<td>Revere, Paul</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>M123456</td>
</tr>
<tr>
<td>Procedures Performed</td>
<td>M123456, M234567</td>
</tr>
<tr>
<td>Amount Charged</td>
<td>$123,456.78</td>
</tr>
<tr>
<td>Amount Paid</td>
<td>$98,765.43</td>
</tr>
<tr>
<td>Balance Due</td>
<td>$24,678.90</td>
</tr>
</tbody>
</table>

The form includes fields for the provider's signature, date, and other necessary details. It is an example of how a PCA claim might be filled out, detailing the services provided, charges, and payments.
PCS – Example Adjustment Form with ICD-10 Diagnosis Code
(Dates ON OR AFTER 10/1/15)
Sample Claim Form