



# **ADULT DAY HEALTH CARE WAIVER (ADHC) PROVIDER MANUAL**

***Chapter Nine of the Medicaid Services Manual***

**Issued October 18, 2013**

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

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

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## OVERVIEW

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

This provider manual chapter specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of federal and state laws and Louisiana Department of Health (LDH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

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

This manual chapter is intended to provide ADHC Waiver providers and support coordination agencies with the information necessary to fulfill its vendor contract with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider or agency to remain in compliance with federal and state laws and department rules.

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

The LDH Bureau of Health Services Financing (BHSF), Office of Aging and Adult Services (OAAS), and Health Standards Section (HSS) are responsible for assuring oversight of the waiver services, licensing and enforcement, program monitoring, and compliance with the applicable rules and regulations.

Waiver services to be provided are specified in each beneficiary's person-centered Plan of Care (POC) which is written by the support coordinator based on input from the planning team. The planning team is comprised of the beneficiary, the support coordinator, and in accordance with the beneficiary's preferences, members of the family/natural support system, appropriate professionals and others whom the beneficiary chooses. The POC contains all services and activities involving the beneficiary, non-waiver as well as waiver services. Beneficiaries are to receive those waiver services included in the POC and approved by the appropriate support coordination designee or OAAS regional office (as applicable). Notification of approved services

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is forwarded to the provider by the support coordinator, and the data contractor issues prior authorization to the providers based on the approved POC.

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the Centers for Medicare and Medicaid Services (CMS).

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### **COVERED SERVICES**

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

#### **Support Coordination**

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

1. Intake;
2. Assessment and re-assessment;
3. Plan of care (POC) development and revision;
4. Follow-up /monitoring;
5. Critical incident management; and
6. Transition/discharge and closure.

Support coordination agencies shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by beneficiaries in receiving direct services.

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

Support coordination agencies must establish and maintain effective communication and good working relationships with beneficiaries’ service providers.



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**Transition Intensive Support Coordination (TISC)**

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

Support coordinators shall comply with all of the requirements described above under the “Support Coordination” section. Support coordinators shall initiate and oversee the process for assessment and re-assessment, as well as be responsible for ongoing monitoring of the provision of services included in the beneficiary’s approved POC. (See Appendix F for a complete list of the ADHC Waiver services available during the transition process).

**Service Exclusions**

Support coordination agencies are not allowed to bill for TISC until after the individual has been approved for the ADHC Waiver.

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

**Service Limitations**

Support coordination agencies may be reimbursed up to six (6) months (not to exceed 180 calendar days) from the POC approval date so long as the beneficiary is residing in the nursing facility. Reimbursement is contingent upon the support coordinator performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the support coordinator. Support coordination agencies will not receive reimbursement for any month during which no activity was performed and documented in the transition process.

**Transition Services**

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

Transition Services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an ADHC Waiver opportunity and are transitioning from a nursing facility to their own living arrangement in a private residence where the individual is directly responsible for his/her own living expenses. Transition services may also be used to purchase essential items needed for the individual even when the individual is residing with others. Allowable expenses are those necessary to enable the individual to establish a basic household,

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excluding expenses for room and board. These services must be identified and approved in the individual's POC in accordance with the Louisiana Department of Health (LDH) and OAAS policies and procedures.

Transition services include the following:

1. Security deposits that are required to obtain a lease on an apartment or house;
2. Specific set-up fees or deposits for:
  - a. Telephone;
  - b. Electricity;
  - c. Gas;
  - d. Water; and
  - e. Other such necessary housing start-up fees or deposits, including outstanding balances for past due charges and/or fees.
3. Activities to assess need, arrange for and procure needed resources (e.g. – fees associated with obtaining photo IDs or vital records, housing application fees, etc.);
4. Essential furnishings to establish basic living arrangements:
  - a. Living Room – sofa/love seat, chair, coffee table, end table and recliner;
  - b. Dining Room – dining table and chairs;
  - c. Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers, nightstand, comforter, sheets, pillows, lamp and telephone;
  - d. Kitchen – refrigerator, stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, dishcloths, towels and potholders;
  - e. Bathroom – towels, hamper, shower curtain and bath mat;
  - f. Miscellaneous - window coverings, window blinds, curtain rod, washer,

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dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron and ironing board; and

- g. Moving Expenses – moving company and cleaners (prior to move, onetime expense).

5. Health and welfare assurances:

- a. Pest control/eradication;
- b. Fire extinguisher;
- c. Smoke detector; and
- d. First aid supplies/kit.

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

**Service Exclusions**

Transition services do not include the following:

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

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

**Service Limitations**

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

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**NOTE:** This is the only waiver service that is NOT subject to the individual's annual POC maximum cost.

When the individual transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the individual.

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

**Adult Day Health Care Services**

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

An ADHC center shall, at a minimum, furnish the following services in accordance with licensing regulations:

1. Training or assistance with activities of daily living (toileting, grooming, eating, ambulation, etc.);
2. Health and nutrition counseling;
3. Individualized daily exercise program;
4. Individualized goal-directed recreation program;
5. Health education;
6. Medical care management;
7. One nutritionally-balanced hot meal and a minimum of two snacks served each day;

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

8. Nursing services that are provided by licensed nursing professionals and that include the following individualized health services:

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- a. Monitoring vital signs appropriate to the diagnosis and medication regimen of each beneficiary no less frequently than monthly;
- b. Administering medications and treatments in accordance with physicians' orders;
- c. Developing and monitoring beneficiaries' medication administration plans (self-administration and staff administered) of medications while the beneficiary is at the ADHC center; and
- d. Serving as a liaison between the beneficiary and medical resources including the treating physician.

**NOTE:** All nursing services shall be provided in accordance with professional practice standards and all other requirements identified in the ADHC Licensing rules.

9. Transportation between the beneficiary's place of residence and the ADHC center at the beginning and end of the program day:
  - a. The cost of transportation is included in the rate paid to ADHC centers. The beneficiary and his/her family may choose to transport the beneficiary to the ADHC center. Transportation provided by the beneficiary's family is not a reimbursable service.

**NOTE:** An ADHC center may serve a person residing outside of the ADHC's licensed region; however, transportation by the ADHC center is not required.

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

**Service Exclusions**

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

**Service Limitations**

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

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

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

### **ADHC Waiver and Long Term-Personal Care Services**

ADHC Waiver beneficiaries may also be eligible to receive Long Term-Personal Care Services (LT-PCS), a Medicaid State Plan service, as long as the beneficiary also meets LT-PCS requirements. Eligibility for LT-PCS is based on the beneficiary's assessment score, which must identify a need of limited assistance or more in the performance of at least one (1) Activities of Daily Living (ADL). For additional information on LT-PCS, refer to Medicaid Provider Manual (Chapter 30) - Personal Care Services.

### **Hospice and Waiver Services**

Beneficiaries who elect hospice services may choose to elect ADHC Waiver and hospice services concurrently. The hospice provider and support coordination agency must coordinate ADHC Waiver and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with ADHC Waiver services.

When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's caregiver and the support coordination agency. The POC must clearly and specifically detail the ADHC Waiver and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

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

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

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**Waiver Services Payable While in a Nursing Facility/Hospital**

Certain ADHC Waiver services are payable when transitioning from a nursing facility or for a beneficiary during a temporary stay in a nursing facility/hospital. (See Appendix F for a complete list of the ADHC Waiver services).

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**SECTION 9.2: BENEFICIARY REQUIREMENTS****PAGE(S) 3**

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**BENEFICIARY REQUIREMENTS**

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

1. Medicaid financial eligibility;
2. Age 65 years or older, **OR** 22 through 64 years of age with a physical disability that meets Medicaid standards or the social Security Administration's disability criteria;
3. Nursing facility level of care requirements;
4. Name on the Request for Services Registry (RFSR) for the ADHC Waiver; and
5. A plan of care (POC) sufficient to:
  - a. Reasonably assure that the health and welfare of the waiver applicant can be maintained in the community with the provision of waiver services; and
  - b. Justify that the ADHC Waiver services are appropriate, cost effective and represent the least restrictive environment for the individual.

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

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

**NOTE:** An individual may only be certified to receive services from one Home and Community-Based Services (HCBS) Waiver at a time.

**Request for Services Registry**

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

Requests for ADHC Waiver services shall be accepted from the following:



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1. The applicant;
2. An individual who is legally responsible for the applicant; or
3. A responsible representative designated by the applicant to act on his/her behalf.

Individuals will be screened and/or assessed to determine whether they meet nursing facility level of care and are members of the target population. Only individuals who meet these criteria will be added to the registry. The individual's name is placed on the registry in request date order.

**NOTE:** If at any time individuals do NOT meet nursing facility level of care, their names will be removed from the ADHC Waiver registry.

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

1. Individuals with substantiated cases of abuse or neglect with Adult Protective Services (APS) or Elderly Protective Services (EPS) and who, absent ADHC Waiver services would require institutional placement to prevent further abuse and neglect as determined by OAAS review;
2. Individuals who have been discharged after a hospitalization within the past 30 calendar days that involved a stay of at least one night;
3. Individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for the nursing facility stay; and
4. All other eligible individuals on the RFSR, by date of first request for services.

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

**Admission Denial or Discharge Criteria**

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

1. The individual does not meet the target population criteria;

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2. The individual does not meet the criteria for Medicaid eligibility;
3. The individual does not meet the criteria for a nursing facility level of care;
4. The beneficiary resides in another state or has a change of residence to another state;
5. Continuity of services is interrupted as a result of the beneficiary not receiving and/or refusing ADHC Waiver services (exclusive of support coordination services) for a period of 30 consecutive days;

**NOTE:** Continuity of services will not apply when interruptions are due to a beneficiary being admitted to an acute care hospital, rehabilitation hospital or nursing facility. This exception is granted by OAAS and will typically not exceed 90 consecutive days.

6. The health and welfare of the individual cannot be reasonably assured through the provision of the ADHC Waiver services;
7. The individual fails to cooperate in the eligibility determination process or in the development/performance of the POC;
8. It is not cost effective to serve the individual in the ADHC Waiver;
9. The beneficiary fails to attend the ADHC center for a minimum of 36 days per calendar quarter; or
10. The individual fails to maintain a safe and legal home environment.

Involuntary discharge/transfer from the ADHC center or ADHC Waiver program may occur for one of the following:

1. Medical protection or the well-being of the individual or others;
2. Emergency situation (i.e., declared or non-declared disasters affecting the ADHC);
3. Health or welfare of the beneficiary is threatened; or
4. Inability of the ADHC provider to furnish the services indicated in the beneficiary's POC after documented reasonable accommodations have failed.

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**SECTION 9.3: BENEFICIARY RIGHTS/RESPONSIBILITIES PAGE(S) 5**

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**BENEFICIARY RIGHTS AND RESPONSIBILITIES**

Beneficiaries have specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs. Support coordinators and service providers must assist beneficiaries to exercise their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid to adhere to the following policies on beneficiary rights.

Each individual who requests Adult Day Health Care (ADHC) Waiver services has the option to designate a responsible representative to assist or act on his/her behalf in the process of accessing and/or maintaining ADHC Waiver services. The beneficiary has the right to change his/her responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than two (2) beneficiaries in a Medicaid Home and Community-Based Services (HCBS) program that is operated by the Office of Aging and Adult Services (unless an exception is granted by OAAS) which includes, but is not limited to the following:

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

**Freedom of Choice of Program**

Individuals who have been offered waiver services have the freedom to select between institutional care services and Home and Community-Based Services (HCBS). They are informed of their alternatives under the waiver at the time they are going through the Medicaid application and determination process. These individuals have the responsibility to participate in this process which includes providing medical and other pertinent information or assisting in obtaining this information to be used in the person-centered planning and service approval process. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

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**Freedom of Choice of Agencies/Providers**

Beneficiaries have the freedom of choice to select their support coordination agency/providers. Beneficiaries may make agency/provider changes based on the following schedule:

Type of Service	Without Good Cause	With Good Cause
Support Coordination Transition Intensive Support Coordination	Beneficiaries must have been with the support coordination agency at least six (6) months	Any time
Adult Day Health Care (ADHC)	Once every six (6) months with the change effective beginning the first day of the following calendar quarter	Any time
Transition Service	Not Applicable	Not Applicable

Good cause is defined as:

1. A beneficiary moving to another region in the state where the current provider/agency does not provide services;
2. The beneficiary and the provider/agency have unresolved difficulties and mutually agree to a transfer;
3. The beneficiary's health or welfare has been compromised; or
4. The provider/agency has not rendered services in a manner satisfactory to the beneficiary.

Support coordinators will provide beneficiaries their choice of ADHC providers and help arrange and coordinate the services on the Plan of Care (POC).

The Office of Aging and Adult Services (OAAS), or its designee will provide beneficiaries with their choice of support coordination agencies.

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### **Adequacy of Care**

All beneficiaries in HCBS waiver programs inclusive of ADHC services have the right to choose and receive the services necessary to support them to live in a community setting. Beneficiaries have the right to choose how, where, and with whom they live. Services are arranged and coordinated through support coordination and approved by the OAAS regional office or its designee. Administrative limits are placed on some services according to the waiver that is authorized by the Center for Medicare and Medicaid Services (CMS).

Beneficiaries have the responsibility to request only those services they need and not request excess services, or services for the convenience of employees, providers or support coordinators. Units of service are not “saved up”. The services are certified as medically necessary for the beneficiary to be able to stay in the community and are revised on the POC as each beneficiary’s needs change. The support coordinator must be informed anytime there is a change in the beneficiary’s health, medication, physical conditions, and/or living situation.

### **Participation in Care**

Each beneficiary shall participate in the assessment, person-centered planning meetings and any other meeting involving decisions about services and supports to be provided as part of the waiver process. Each beneficiary may choose whether or not providers attend assessment and planning meetings. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary’s needs. By taking an active part in planning his/her services, the beneficiary is better able to utilize the available supports and services. The beneficiary is expected to participate in the planning process to the best of the beneficiary’s ability so that services can be delivered according the approved person-centered POC. The beneficiary shall report any service need change to his/her support coordinator and service provider(s).

Changes in the amount of services must be requested by the beneficiary and submitted to the support coordinator as soon as the need is identified. The support coordinator will prepare and submit the POC revision in accordance with the required timelines. Providers may not initiate requests for change/adjustment of service(s), or modifications to the POC, without the participation and consent of the beneficiary. The OAAS regional office or its designee must approve these changes.

### **Voluntary Participation**

Beneficiaries have the right to refuse services, to be informed of the alternative services available to them, and to know the consequences of their decisions. Therefore, a beneficiary will not be required to receive services or participate in activities they do not want, even if they are eligible for those services. The intent of the ADHC Waiver is to provide community-based services to

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individuals who would otherwise require care in a nursing facility.

Providers must reasonably assure that the beneficiary's health and welfare needs are met. As part of the planning process, methods to comply with these assurances may be negotiated to suit the beneficiary's needs.

### **Quality of Care**

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

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

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

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

Beneficiaries must maintain a safe and lawful home environment and may not request providers to perform tasks that are illegal or inappropriate, and they may not violate the rights of other beneficiaries.

### **Civil Rights**

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

### **Notification of Changes**

The Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the ADHC Waiver beneficiaries. In order to maintain eligibility, beneficiaries and

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providers have the responsibility to inform BHSF of changes in the beneficiary's income, resources, address, and living situation.

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

### **Grievances/Complaints**

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

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

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

### **Fair Hearings**

Beneficiaries must be advised of their rights to appeal any agency action or decision resulting in suspension, reduction, discontinuance, or termination of services. Beneficiaries have the right to a fair hearing through the Division of Administrative Law (DAL). In the event of a fair hearing, a representative of the service provider and support coordination agency must participate by telephone or in person, if requested.

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

### **Rights and Responsibilities Form**

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

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**SERVICE ACCESS AND AUTHORIZATION**

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

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

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

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

1. The types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the beneficiary safely in the community;
2. The individual cost of each waiver service; and
3. The total cost of waiver services covered by the POC.

**Provider Selection**

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

The support coordinator is responsible for the following:

1. Notifying the selected provider that they have been chosen by the beneficiary to provide the necessary services;



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2. Completing assessments and POCs;
3. Obtaining an agreement to provide services and copies of any completed assessments and/or plans written by the provider; and
4. Forwarding the POC packet to the Office of Aging and Adult Services (OAAS) regional office or its designee, as applicable for review and approval following the established protocol.

**NOTE:** Authorization to provide service is always contingent upon having an approved POC or POC revision.

**Prior Authorization**

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

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

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

The ADHC provider is responsible for the following activities:

1. Developing an Individual Service Plan (ISP) in accordance with the approved POC and as stipulated in the ADHC licensing regulations and Medicaid certification rules (LAC 50. XXI.2303. A.);
2. Checking PAs to verify that they match the approved services in the beneficiary's POC and any mistakes must be immediately corrected;

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3. Verifying that services were documented as evidenced by time entries, attendance records, progress notes and progress summaries and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;
4. Verifying that services were delivered according to the beneficiary's approved POC prior to billing for the service;
5. Proper use of the Electronic Visit Verification (EVV) system;
6. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;
7. Billing only for the services that were delivered to the beneficiary and are approved in the beneficiary's POC;
8. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary with each payment; and
9. Checking billing records to ensure that the appropriate payment was received.

**NOTE:** Providers have one-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in Chapter General Information and Administration of the *Medicaid Services Manual* at:

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

### Support Coordination

The data contractor issues authorizations for support coordination service for the POC year. A service unit is one month and each authorization covers a maximum of seven months, or seven service units. Typically, two PAs will be issued for a one year POC. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

### Transition Intensive Support Coordination (TISC)

Authorization for TISC is issued upon receipt of the POC (provisional or initial). A service unit is one month. The authorization includes a unit of service for each month with a maximum of six (6) units of service per authorization. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

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**NOTE:** Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances as determined and approved by OAAS.

**Transition Services**

Authorization for Transition Services has a lifetime cap of \$1,500. The authorization period is the effective date indicated on the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the “Transition Services Form” are sent to the data contractor. (See Appendix B for a copy of this form).

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

**Adult Day Health Care Services**

ADHC service units are 15 minutes. Adult Day Health Care (ADHC) services are assigned a PA number for the year. Approved units of service are issued on a quarterly basis. Units of service approved for one week cannot exceed established limits. For PA purposes, a week is defined as beginning at 12:00 a.m. Sunday and ending at 11:59 p.m. the following Saturday. Payment for services is capped at 50 hours per week and no more than 10 hours per day.

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

**Post Authorization**

Some services require post authorization before the provider is able to bill for services rendered. Post authorization may occur either through EVV or documentation submitted by the support coordinator.

<b>EVV</b>	<b>Additional Documentation</b>
Adult Day Health Care (ADHC)	Transition Services

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

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

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**Changing ADHC Providers**

Beneficiaries or their responsible representative must request any change in amount(s) of service/units to the support coordinator.

All requests for changes in ADHC providers require a new Freedom of Choice by the beneficiary or his/her responsible representative. (Refer to 9.3- Beneficiary Rights and Responsibilities, Freedom of Choice of Agencies/Providers, for details on “good cause” criteria and timelines).

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

1. Progress notes from the last six (6) months, or if the beneficiary has received services from the provider for less than six (6) months, all progress notes from date of admission;
2. Written documentation of services provided, including monthly and quarterly progress summaries;
3. Current ISP;
4. Current assessments upon which the ISP is based;
5. A summary of the beneficiary’s behavioral, social, health and nutritional status;
6. Records tracking beneficiary’s progress towards ISP goals and objectives;
7. Documentation of the amount of authorized services remaining in the POC, including direct service case record documentation; and
8. Documentation of exit interview.

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

1. Most current POC;
2. Current assessments on which the POC is based;

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3. Number of services used in the calendar year; and
4. All other waiver documents necessary for the new ADHC provider to begin providing services.

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

**Prior Authorization for New ADHC Providers**

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

**Changing Support Coordination Agency**

A beneficiary may change to a different support coordination agency for any reason after being with that agency for six (6) months, or at any time for good cause, as long as the new agency has not met its maximum number of beneficiaries, and as approved by the OAAS regional office or its designee.

Good cause is defined as the following:

1. A beneficiary moving to another region in the state;
2. The beneficiary and the support coordination agency have unresolved difficulties and mutually agree to a transfer;
3. The beneficiary's health, safety or welfare has been compromised; or
4. The support coordination agency has not rendered services in a manner satisfactory to the beneficiary.

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

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

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1. Most current POC;
2. Current assessments on which the POC is based;
3. Number of services used in the POC year; and
4. Most recent six (6) months of progress notes.

**NOTE:** The new support coordination agency must bear the cost of copying which cannot exceed the community's competitive copying rate. If the new agency does not receive the information in a timely fashion, the appropriate OAAS regional office should be contacted for assistance.

The transferring support coordination agency must provide services up to the transfer of records and is eligible to bill for support coordination services for the month in which the dated notification is received (transfer of records) by the receiving agency.

In the month the transfer occurs, the receiving agency shall begin services within three (3) days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. Immediately after the transfer of records, the receiving agency must submit the required documentation to the data contractor to obtain prior authorization.

**Prior Authorization for New Support Coordination Agency**

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

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

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**PROVIDER REQUIREMENTS**

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

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

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

Providers must not have been terminated or actively sanctioned by Medicaid, Medicare or other health-related programs in Louisiana or any other state. The provider must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in R.S. 40:1203.1 et seq. Providers are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must determine whether applicants for employment have histories indicating involvement in abuse, neglect or mistreatment, or a criminal record involving physical harm to an individual.

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

1. Recoupment;
2. Sanctions;
3. Loss of enrollment; or
4. Loss of licensure.

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Providers must also check the certified nursing assistant (CNA) and direct service worker (DSW) Registries for placement of findings of abuse, neglect, or misappropriation and shall be in accordance with licensing regulations.

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

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

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

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

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

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

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

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



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*Policies and Procedures* manual).

Each ADHC provider shall complete the LDH approved cost report and submit the cost report(s) to the designated LDH contractor on or before the last day of September following the close of the cost reporting period. (See Appendix A to obtain web address for additional information).

**Licensure and Specific Provider/Agency Requirements**

Providers, or agencies, must meet licensure and/or certification and other additional requirements as outlined in the tables below and in other sections of 9.5:

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

Provided by a **support coordination agency** that:

1. Is certified by LDH /OAAS to provide support coordination services;
2. Has signed the OAAS Performance Agreement;
3. Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training;
4. Has a brochure that has been approved by OAAS;
5. Has submitted a completed OAAS agency contact information form to OAAS;
6. Has enrolled as a Medicaid provider of support coordination services in all regions in which it intends to provide services; and
7. Is listed on the Support Coordination Agency FOC form.

**Adult Day Health Care (ADHC)**

Provided by an **ADHC provider** that:

1. Is licensed by the LDH Health Standards Section (HSS) as an ADHC provider in accordance with Louisiana Revised Statute 40:2120.47;
2. Has enrolled in Medicaid as an ADHC provider; and
3. Is listed on the ADHC FOC form.

**NOTE:** Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code.

**Provider Responsibilities**

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

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Providers shall not refuse to serve any beneficiary who chooses their agency, unless there is documentation to support an inability to meet the beneficiary's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services.

Refusal to serve a beneficiary must be put in writing by the provider to the support coordinator and the beneficiary. This written notice must provide a detailed explanation as to why the provider is unable to provide services to the beneficiary. Upon receipt of this written documentation, the support coordinator is to forward the notice to the OAAS regional office for approval/refusal.

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

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

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

1. The provider shall give written notice to the beneficiary, a family member and/or the responsible representative, if known, and the support coordinator at least 30 calendar days prior to the transfer or the discharge;
2. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the beneficiary understands;
3. A copy of the written discharge/transfer notice shall be put in the beneficiary's record; and
4. When the safety or health of beneficiaries or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge:
  - a. The written notice shall include the following:
    - i. A reason for the transfer or discharge;
    - ii. The effective date of the transfer or discharge;
    - iii. An explanation of a beneficiary's right to personal and/or third party

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representation at all stages of the transfer or discharge process;

iv. Contact information for the Advocacy Center;

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

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

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

viii. The name of the director, current address and telephone number of the Division of Administrative Law; and

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

Provider transfer or discharge responsibilities shall include the following:

1. Developing a written report detailing the circumstances leading to any discharge;
2. Holding a transfer or discharge planning conference with the beneficiary, family, support coordinator, legal representative and advocate, if such is known;
3. Developing a discharge plan that specifies the beneficiary's needed supports and the resources available to him/her after discharge and includes options that will provide reasonable assurance that the beneficiary will be transferred or discharged to a setting that can be expected to meet his/her needs;
4. Providing all services required and contained in the final update of the service plan and in the transfer or discharge plan up until the transfer or discharge;
5. Coordinating and consulting with the receiving center or other program (if applicable) to discuss the beneficiary's needs as warranted; and
6. Preparing and submitting to the receiving center or program an updated discharge service plan and written discharge summary of the beneficiary's needs and health that shall include, at a minimum:
  - a. Medical diagnoses;
  - b. Medication and treatment history/regimen (current physician's orders);

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- c. Functional needs (inabilities);
- d. Any special equipment utilized (dentures, ambulatory aids, eyeglasses, etc.);
- e. Social data and needs;
- f. Financial resources; and
- g. Any other information which would enable the receiving ADHC center/caregiver(s) to provide the continued necessary care without interruption.

**Support Coordination Agencies**

Support coordination agencies must meet the following criteria:

1. Meet all of the requirements included in the OAAS support coordination performance agreement, the OAAS Home and Community-Based Services (HCBS) Waivers Support Coordination Standards for Participation rule, and comply with all LDH and OAAS policies and procedures;
2. Maintain a toll-free telephone line with 24-hour accessibility manned by an answering service. This toll-free number must be given to beneficiaries at intake or at the first meeting with the beneficiary;
3. Have brochures that provide information about their agency's experience, including the provider's toll-free number and the OAAS toll-free information number;
4. Assure staff attends all training mandated by OAAS;
5. Furnish information and assistance to beneficiaries in directing and managing their services; and
6. Provide the beneficiary's approved POC to the ADHC provider in a timely manner.

**ADHC Providers**

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

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1. Administrative: Employment and personnel job descriptions; hiring practices including a policy against discrimination; employee evaluation, promotion, disciplinary action, termination and hearing of employee grievances; staffing and staff coverage plan;
2. Employment Qualifications: Must possess direct care abilities, skills and knowledge to adequately perform care and assistance as required by waiver beneficiaries;
3. Training: Staff orientation in safety and emergency procedures as stipulated by LDH licensing and certification rules and regulations;
4. Records: Maintenance, security, supervision, confidentiality, organization, transfer and disposal;
5. Beneficiary Rights: Identification, notification and protection of beneficiary's rights both verbally and in writing in a language the beneficiary/family is able to understand;
6. Grievances: Written grievance procedures;
7. Abuse/Neglect: Information about abuse and neglect as defined by LDH regulations and state and federal laws; reporting responsibilities;
8. Discharges: Voluntary and involuntary discharges/transfers from their center; and
9. EVV: Requirements/proper use of check in/out; acceptable editing of electronically captured services; confidentiality of log in information; and monitoring for proper use.

ADHC providers must also:

1. Comply with all applicable LDH rules and regulations including the use of an approved Electronic Visit Verification (EVV) system;
2. Provide transportation to any beneficiary within their licensed region in accordance with ADHC licensing standards; and
3. Provide the beneficiary's approved Individualized Service Plan (ISP) to the support coordinator in a timely manner.

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

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

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

1. Administrative;
2. Fiscal;
3. Clerical;
4. Housekeeping, maintenance and food service;
5. Direct services;
6. Supervision;
7. Record-keeping and reporting;
8. Social services; and
9. Ancillary services.

The ADHC provider shall ensure the following:

1. All non-licensed direct care staff members meet the minimum, mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-2179.1;
2. All staff members are properly certified and/or licensed as legally required;
3. An adequate number of qualified direct service staff is present with beneficiaries as

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necessary to ensure the health and welfare of beneficiaries;

4. Procedures are established to assure adequate communication among staff in order to provide continuity of services to beneficiaries to include:
  - a. Regular review of individual and aggregate problems of beneficiaries, including actions taken to resolve these problems;
  - b. Sharing daily information, noting unusual circumstances and other information requiring continued action by staff; and
  - c. Maintenance of all accidents, injuries, and incident records related to beneficiaries.
5. Employees working with beneficiaries have access to information from case records necessary for effective performance of the employees' assigned tasks;
6. A staff member who has knowledge of and can apply first aid and who is certified in CPR must be in the ADHC center at all times;
7. A staff member shall is designated to supervise the ADHC center in the absence of the director;
8. A written plan of emergency and safety procedures that includes training staff on their duties when responding to emergencies and evacuating beneficiaries to safe or sheltered areas; and
9. All furnishings and equipment are
  - a. Kept clean;
  - b. In good repair; and
  - c. Appropriate for use by the beneficiaries in terms of comfort and safety.

Each ADHC provider shall ensure that its setting is integrated in and supports full access to the greater community including the option to seek employment in integrated settings if desired, engaging in community life, and to receive services in the community to the same degree of access as individuals not receiving Medicaid (HCBS).

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**Changes**

The following changes are reported, in writing, to the Health Standards Section (HSS), OAAS and the fiscal intermediary's Provider Enrollment Section, within five (5) working days of the actual change:

1. Name of the ADHC center;
2. Physical location;
3. Mailing address;
4. Contact information (i.e. telephone number, fax number, email address); and
5. Key administrative staff (e. director, program manager, social service designee, RN/ LPN, etc.).

When a change of ownership (CHOW) occurs, the ADHC provider shall notify HSS in writing within 15 days prior to the effective date of the CHOW.

When an ADHC provider closes or decides to no longer participate in the Medicaid program, the provider must provide at least 30-day written advance notice to beneficiaries and their responsible representatives, support coordination agencies, and LDH (OAAS and HSS) prior to discontinuing service.



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## SECTION 9.6: RECORD KEEPING

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## RECORD KEEPING

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>)

**NOTE:** For this section 9.6-Record Keeping, the term “provider” is used to refer to either the ADHC provider or the support coordination agency.

### Components of Record Keeping

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

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

### Retention of Records

The provider must retain administrative, personnel, and beneficiary records for a minimum of six years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six (6) years).

**NOTE:** Upon provider closure, all 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 beneficiary, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use.

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Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, the beneficiaries or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiaries or their families. The information may be released only under the following conditions:

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

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

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

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

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

Beneficiary records must be located at the enrolled site.

**NOTE:** Under no circumstances should providers allow staff to take beneficiary's case records from the ADHC center.

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**Review by State and Federal Agencies**

Providers must make all administrative, personnel, and beneficiary records available to LDH or its designee and appropriate state and federal personnel within the specified timeframe given by LDH or its designee. Providers must always safeguard the confidentiality of beneficiary information.

**Beneficiary Records**

Providers must have a separate written record for each beneficiary served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, support coordination agencies and service providers must have on-going adequate chronological documentation of services offered and provided to beneficiaries they serve.

See tables below for specific information regarding documentation of services.

<b>SUPPORT COORDINATION/TRANSITION INTENSIVE SUPPORT COORDINATION SERVICES</b>	
<b>Monthly Contacts</b>	Complete each calendar month at the time of the monthly monitoring contact, according to the Office of Aging and Adult Services (OAAS) documentation and data entry requirements.
<b>Interim Contacts</b>	Complete at the time of interim activities, according to OAAS documentation and data entry requirements.
<b>Quarterly Contacts</b>	Complete each calendar quarter at the time of the quarterly monitoring contact, according to OAAS documentation and data entry requirements.
<b>Annual Contacts</b>	Complete in the last month of the POC year at the time of the annual monitoring contact, according to OAAS documentation and data entry requirements.  <b>NOTE: The annual monitoring may be performed at the same time as the monthly monitoring or at another time during the last month of the POC year.</b>
<b>Case Closure/Transfer</b>	Complete within 14 calendar days of discharge.

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TRANSITION SERVICES	
<b>Receipts/Cancelled Checks</b>	Document deposits, set-up fees, or items purchased and reimbursement made to purchaser(s) if outside of support coordination agency.
<b>Transition Services Form (TSF)</b>	Complete to obtain applicable approval for prior authorization.

ADULT DAY HEALTH CARE SERVICES	
<b>Attendance Log</b>	Complete daily with date and time of arrival and date and time of departure. <b>NOTE: An EVV system generated report satisfies this requirement.</b>
<b>Progress Notes</b>	Complete at least weekly and when there is a change in the beneficiary's condition or routine.
<b>Progress Summary</b>	Complete at least every 90 calendar days.
<b>Case Closure/Transfer</b>	Complete within 14 calendar days of discharge.

**Organization of Records, Record Entries and Corrections**

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

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

1. The name of the person making the entry;
2. The signature of the person making the entry;
3. The functional title of the person making the entry;
4. The full date of documentation; and

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5. Reviewed by the supervisor, if required.

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

**Progress Notes and Summaries**

Progress notes document the daily delivery of services, activities, and observations, and it records the progress made toward meeting service goals in the beneficiary's Individualized Service Plan (ISP) and plan of care (POC).

Progress summaries are completed every 90 calendar days and provide an overview which addresses significant activities, progress toward the beneficiary's desired personal outcomes, and any changes in the beneficiary's status and service needs.

Progress notes must:

1. Document delivery of services identified on the POC and the ISP, as applicable;
2. Record activities and actions taken (by whom, where, etc.);
3. Provide adequate descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note;

**NOTE:** General statements, such as "called the beneficiary"; "supported beneficiary"; or "assisted beneficiary", do NOT provide enough detail and are NOT sufficient. Check lists alone are NOT adequate documentation.

4. Record the progress (or lack of progress) being made and indicate whether the approaches in the POC and ISP are working;
5. Record any changes in the beneficiary's medical condition, behavior or home situation that may indicate a need for a re-assessment and POC and ISP change, if applicable;

**NOTE:** If there is a change in the beneficiary's condition or his/her normal routine, this must be recorded on the day of the actual occurrence.

6. Document the completion of incident reports, when appropriate;

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7. Document any significant deviation from the POC and/or ISP, Examples include but are not limited to the following:
  - a. Provided more assistance than what is indicated in the POC/ISP due to the beneficiary's request or increased need;
  - b. Assistance not provided with a particular task/subtask as indicated in the POC/ISP due to beneficiary's request or lack of need; and
  - c. Significant deviation from the POC's flexible scheduled arrival/departure time.

**NOTE:** Arriving or departing within a reasonable amount of time (e.g. 15 minutes of the flexible schedule's time) due to everyday factors such as 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.

8. Be signed by the person providing the services.

Progress summaries must:

1. Take into account all of the progress notes and document significant trends, progress/lack of progress towards the personal outcomes and changes that may have impacted the POC and/or ISP and the needs of the beneficiary;
2. Include recommendations for any modifications to the POC and/or ISP as necessary; and
3. Be completed and updated by the supervisor (if applicable).

**BOTH** progress notes and progress summaries must:

1. Be in narrative format;
2. Be legible (including signature) and include the functional title of the person making the entry and date; and
3. Be entered in the beneficiary's record when a case is transferred or closed.

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**Discharge Summary for Transfers and Closures**

In accordance with Medicaid licensing requirements, the ADHC center must provide a summary of the beneficiary's health record prior to the transfer/closure to the person or agency responsible for the future planning and care of the beneficiary. The ADHC center must also include any other information, including a progress summary, which would enable the receiving ADHC center/caregivers to provide the continued necessary care.

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**REIMBURSEMENT**

Reimbursement for Adult Day Health Care (ADHC) Waiver services shall be a prospective flat rate for each approved unit of service provided to the beneficiary. Support coordination agencies and ADHC providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. (See to Appendix C of this manual chapter for information about procedure codes, units of service and current reimbursement rate).

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

**Support Coordination**

Support coordination is reimbursed at an established monthly rate. (See to Appendix C – Billing Codes). The data contractor issues a monthly authorization to the support coordination agency. After the support coordination requirements are met and documented in the case management database, the authorization is released to the support coordination agency. For each quarter in the beneficiary’s plan of care (POC) year, if the support coordination agency does not meet all of the requirements for documentation in the case management database, the prior authorization (PA) for the last month of that quarter will not be released until all requirements are met and the “Request for Payment/Override Form” has been completed and submitted to the office of Aging and Adult Services (OAAS) Regional Office for approval.

**Transition Intensive Support Coordination (TISC)**

The TISC is reimbursed at an established monthly rate (see to Appendix C – Billing Codes), for a maximum of six months (not to exceed 180 calendar days) from the POC approval date so long as the participant is residing in the nursing facility. Payment will not be authorized until the data contractor receives an approved POC indicating that the individual was/is a nursing facility resident during the time period in which prior authorization is requested.

**Transition Services**

Transition services are reimbursed only for the exact amount of expenditures indicated on final approval and supporting documentation. Only one authorization for transition services is issued. The authorization period is the effective date of the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the “Transition Services Form (TSF)” are sent to the data contractor. (See Appendix B for a copy of this form).

The support coordination agency is then notified of the release of the authorization and can bill the



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Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

The OAAS Regional Office, or its designee, shall maintain documentation, including each individual's TSF with original receipts and copies of canceled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes.

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

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

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

**NOTE:** If it is determined that the individual has additional needs that were not identified, or billing was not able to occur, within the above established timelines, the OAAS Regional Office must notify OAAS State Office to review for exception.

**ADHC Services**

ADHC providers are reimbursed at a per quarter-hour-rate for services provided under a Prospective Payment System (PPS) that recognizes and reflects the cost of direct care services provided.

Release of PA for ADHC is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. The use of EVV is mandatory for ADHC services. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OAAS. The system is to be used to electronically "check in" and "check out" waiver participants when they arrive and when they leave the ADHC center. While there may be some circumstances that require manual edits, these should only be occasional.

The transportation component of ADHC is exempt from this mandatory EVV requirement. However, using the EVV system to electronically record when beneficiaries get on/off the ADHC transportation vehicle may be beneficial to the ADHC provider in preventing overlaps with in-home services and for cost reporting.

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In the event of an overlap, the provider that uses the EVV system (i.e. data has not been manually added or edited) will have priority for payment.

**Span Date Billing**

Specific services may be billed as span-dated. Each line on the claim form must represent billing for a single date of service for those services that cannot be span-dated. The following table identifies which ADHC Waiver services can or cannot be span-dated:

Services that <b><u>CANNOT</u></b> be Span-Dated	Services that <b><u>CAN</u></b> be Span-Dated
Adult Day Health Care	Support Coordination
Transition Services	Transition Intensive Support Coordination

Details about when claims can be filed for individual ADHC Waiver services can be found in Section 9.4 – Service Access and Authorization of this manual chapter.

**ADHC Provider Cost Reporting**

ADHC providers are required to file acceptable annual cost reports of all reasonable and allowable costs.

**NOTE:** Title 50 of the Louisiana Administrative Code (LAC) lists all allowable and non-allowable costs and all criteria for an acceptable cost report for ADHC providers.

The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than six (6) years following the date reports are submitted to the BHSF or its designee. A chart of accounts and an accounting system on accrual basis, or converted to the accrual basis at year's end, are required in the cost report preparation process. BHSF or its designee will perform desk reviews or audits of the cost reports. A representative number of the centers shall be subject to a full-scope, annual on-site audit. All ADHC cost reports must be filed based on a fiscal year from July 1 through June 30 and filed on or before the last day of September following the close of the cost reporting period.

**NOTE:** Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date will be the following business day.

All ADHC centers must use the cost reporting forms and instructions developed by BHSF or its designee. Hospital-based and other provider based ADHCs which use Medicare forms for step down in completing their ADHC Medicaid cost reports must submit copies of the applicable Medicare cost report forms.

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The Louisiana Administrative Code, Title 50 Subpart 3, Chapter 29 provides detailed information on cost and annual reporting for adult day health care centers. Providers may also reference the contact information in Appendix A to obtain information on cost report training and templates.

**ADHC Provider Audits**

All Medicaid ADHC providers are subject to financial and compliance audits, as well as audits by state or federal regulators or their designees. Audit selection is at the discretion of the Louisiana Department of Health (LDH). In the event of an audit, the ADHC Waiver provider is responsible for full cooperation as outlined in the LAC, Title 50, Subpart 3, Chapter 29.

If a center has repeat findings and adjustments in audit results, LDH may:

1. Withhold vendor payments until the center submits documentation that the non-compliance has been resolved;
2. Exclude the provider's cost from the database used for rate setting purposes; and
3. Impose civil monetary penalties until the center submits documentation that confirms the non-compliance has been resolved.

If the auditors determine that a center's financial and/or census records are un-auditable, the vendor payments may be withheld until the center submits auditable records. The provider shall be responsible for costs incurred by the auditors when additional services or procedures are performed to complete the audit.

Vendor payments may also be withheld under the following conditions:

1. A center fails to submit corrective action plans in response to financial and compliance audit findings within 15 calendar days after receiving the notification letter from the auditor; or
2. A center fails to respond satisfactorily to the request for information within 15 calendar days after receiving the notification letter.

The ADHC provider must cooperate with the audit process by:

1. Promptly providing all documents needed for review;
2. Providing adequate space for uninterrupted review of records;
3. Making persons responsible for center records and cost report preparation available

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during the audit;

4. Arranging for all pertinent personnel to attend the closing conference;
5. Insuring that complete information is maintained in beneficiary's records; and
6. Developing a plan of correction for areas of non-compliance with state and federal regulations immediately after the exit conference time limit of 30 calendar days.

**ADHC Rate Determination**

The methodology for calculating each individual component of the overall ADHC rate is a product of the median cost multiplied by an index factor as approved by administrative Rule detailed in the LAC for ADHC providers - Provider Reimbursement. The resultant calculations provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC services. The base rate is calculated using the most recent audit or desk review cost for all ADHC providers filing acceptable full year cost reports and includes the following components:

1. Direct care;
2. Care related costs;
3. Administrative and operating costs;
4. Property/capital costs; and
5. Transportation costs.

Because of the wide variation in transportation cost, which is influenced by the rural or urban location of the ADHC center and the number of beneficiaries using the ADHC's transportation services versus other means of transportation (e.g. transportation provided by family, etc.), the transportation component of ADHC reimbursement is calculated and paid individually to each ADHC center.

**Exclusions from the ADHC Rate Determination Database**

The following ADHC providers will be excluded from the database used to calculate the rates:

1. Providers with disclaimed audits; and
2. Providers with cost reports other than a 12-month period.

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**SECTION 9.8: PROGRAM OVERSIGHT AND REVIEW****PAGE(S) 6**

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### **PROGRAM OVERSIGHT AND REVIEW**

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

The OAAS regional office staff conduct on-site reviews of support coordination agencies. Details about the support coordination monitoring process are provided to support coordination agencies at the time of enrollment.

#### **Health Standards Section Reviews**

HSS reviews include an examination of administrative records, personnel records, and a sample of beneficiary records. In addition, ADHC providers are monitored with respect to the following:

1. Beneficiary access to needed services identified in the Plan of Care (POC) and Individualized Service Plan (ISP);
2. Quality of assessment and service planning;
3. Appropriateness of services provided including content, intensity, frequency and beneficiary input and satisfaction; and
4. Internal quality improvement.

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

#### **On-Site Reviews**

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

1. Administrative Review;
2. Personnel Record Review;

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3. Interviews; and
4. Beneficiary Record Reviews.

**Administrative Review**

The Administrative Review includes the following:

1. A review of administrative records;
2. A review of other agency documentation; and
3. Provider staff interviews as well as interviews with beneficiaries sampled to determine continued compliance with provider participation requirements.

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

**Personnel Record Review**

The personnel record review includes the following:

1. A review of personnel files;
2. A review of time sheets;
3. A review of the current organizational chart; and
4. Provider staff interviews to ensure that direct care staff and all supervisors meet the following staff qualifications:
  - a. Education;
  - b. Experience;
  - c. Skills;
  - d. Knowledge;
  - e. Employment status;
  - f. Hours worked;

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- g. Staff coverage;
- h. Supervision documentation; and
- i. Other applicable requirements.

**Interviews**

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

- 1. A representative sample of the individuals served by each provider employee;
- 2. Members of the beneficiary's network of support, which may include family and friends;
- 3. Direct care staff; and
- 4. Other members of the beneficiary's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, direct service providers and other employees of the ADHC center.

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

**Beneficiary Record Review**

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

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

- 1. Identified in the POC and ISP (if applicable);
- 2. Provided to the beneficiary;
- 3. Documented properly; and

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4. Are appropriate in terms of frequency and intensity.

The HSS staff will review the intake documentation of the ADHC Waiver beneficiary's eligibility and procedural safeguards, support coordination and professional assessments/reassessment documentation, service plans, service logs, progress notes and other pertinent information in the beneficiary record.

**Report of Review Findings**

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

The review report includes the following:

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

The HSS program managers will review the reports and assess any sanctions as appropriate.

**Corrective Action Report**

The provider is required to submit a plan of correction to HSS within ten (10) working days of receipt of the report.

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

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

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



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**Informal Dispute Resolution (Optional)**

In the course of the review process, providers may request an informal hearing with HSS staff. The provider is notified of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits the providers' rights to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix A for contact information).

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

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

The HSS program manager convenes the informal hearing and will conduct the hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the monitoring findings. The provider representatives are advised of the date that a written response will be sent and are reminded of its right to a formal appeal.

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

**Fraud and Abuse**

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

**Support Coordination Monitoring**

The OAAS regional staff conducts annual monitoring of each support coordination agency as a means of monitoring compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by beneficiaries served. The results of the monitoring process are reported to the support coordination agency along with any required follow-up actions and timelines. Recurrent problems are to be addressed by the support coordination agency through

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systemic changes resulting in improvements. Support coordination agencies who do not perform all of the required follow-up actions according to the specified timelines are subject to sanctions.

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

1. Offering full cooperation with OAAS;
2. Providing policy and procedure manuals, personnel records, case records, and other documentation, as requested;
3. Providing space for documentation review and support coordinator interviews;
4. Coordinating with agency support coordinator interviews; and
5. Assisting with scheduling beneficiary interviews.

Providers may refer to Appendix B of this manual chapter for further information regarding the support coordination monitoring process.

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**SECTION 9.9: INCIDENTS/ACCIDENTS/COMPLAINTS****PAGE(S) 3**

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## **INCIDENTS, ACCIDENTS AND COMPLAINTS**

Support coordinators and adult day health care (ADHC) providers are responsible for reasonably ensuring the health and welfare of the beneficiary and are required to report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion. Reporting shall be in accordance with applicable laws, rules and policies and be made to the appropriate agency named below. Reporting only to a supervisor does not satisfy the legal requirement to report. The supervisor must be responsible for ensuring that reports or referrals are made in a timely manner to the appropriate agency.

### **Incident/Accident Reports**

Providers are responsible for documenting and maintaining records of **all incidents and accidents** involving the beneficiary. A report of the incident/accident must be maintained in a central records system. The report shall include, at a minimum, the following:

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

### **Critical Incident Reports**

Additional provider responsibilities apply to incidents defined as critical. Critical incidents include, but are not limited to, those involving the following:

1. Abuse;
2. Neglect;
3. Exploitation;
4. Extortion;

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5. Major injury;
6. Major medical events;
7. Death;
8. Major behavioral incidents;
9. Involvement with law enforcement;
10. Loss or destruction of a beneficiary's home;
11. Falls; and
12. Major medication incidents.

Critical incidents are fully defined in the Office of Aging and Adult Services' (OAAS) *Critical Incident Reporting Policy and Procedures* and include the specific provider responsibilities that must be followed. Non-compliance will result in administrative actions. (See Appendix B for information on obtaining this policy).

### **Imminent Danger and Serious Harm**

Providers shall report all suspected cases of abuse (physical, mental, emotional and/or sexual), neglect, exploitation or extortion to the appropriate authorities. In addition, any other circumstances that place the beneficiary's health and welfare at risk should be reported to the appropriate authorities. (See Appendix A for contact information).

For beneficiaries ages 18 through 59 and emancipated minors, Adult Protective Services (APS) must be contacted. An APS staff investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect, exploitation or extortion. (See Appendix A for contact information).

For beneficiaries ages 60 or older, Elderly Protective Services (EPS) must be contacted. EPS investigates situations of abuse, neglect and/or exploitation of individuals age 60 or older. (See Appendix A for contact information).

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

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

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## SECTION 9.9: INCIDENTS/ACCIDENTS/COMPLAINTS

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### Internal Complaint Policy

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

1. Designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator must maintain a log of all complaints received. The complaint log must include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint;
2. Forward all written complaints to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator;
3. The complaint coordinator must send a letter to the complainant acknowledging receipt of the complaint **within five (5) working days**;
4. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the beneficiary, the responsible representative, the employee, and other interested parties. The agency/provider is encouraged to use all available resources to resolve the complaint internally. The employee's supervisor must be informed of the complaint and the resolution; and
5. The agency/provider must inform the beneficiary, the complainant, and/or the responsible representative in writing **within ten (10) working days** of receipt of the complaint and the results of the internal investigation.

If the beneficiary is dissatisfied with the results of the provider's internal investigation, he/she may continue the complaint resolution process by contacting Health Standards Section (HSS). (See Appendix A for contact information).

If the beneficiary is dissatisfied with the results of the support coordination agency's internal investigation, he/she may continue the complaint resolution process by contacting the OAAS regional office. (See Appendix A for contact information).

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**SECTION 9.10: SUPPORT COORDINATION****PAGE(S) 2**

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**SUPPORT COORDINATION**

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

**Core Elements**

Support coordination agencies are required to perform the following:

1. Intake;
2. Assessment/reassessment:
  - a. Evaluation/re-evaluation of level of care (LOC) and need for waiver services.
3. Plan of care (POC) development and revision of POC:
  - a. Linkage to direct services and other resources; and
  - b. Coordination of multiple services among multiple providers.
4. Follow-Up/monitoring:
  - a. On-going assessment and mitigation of health, behavioral and personal safety risk; and
  - b. Responding to beneficiary crisis.
5. Critical incident management; and
6. Transition/discharge and closure.

For additional details on support coordination responsibilities, procedures, and timelines, refer to Appendix B for the hyperlink to the *Office of Adult and Aging Services (OAAS) Waiver Procedures Manual*.

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**SECTION 9.10: SUPPORT COORDINATION****PAGE(S) 2**

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**Other Support Coordination Responsibilities**

The support coordinator is responsible for managing the beneficiary's ADHC Waiver services and long-term personal care services (LT-PCS), if applicable, in a way that does not duplicate services when the beneficiary is also receiving other services, such as home health or hospice services.

Support coordinators are also responsible for reporting critical incidents. For additional details regarding reporting requirements, procedures and timelines, refer to Appendix B for the hyperlink to the *Critical Incident Reporting* website.

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## APPENDIX A – CONTACT INFORMATION

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## CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
OAAS State Office	Provides waiver assistance, clarification of waiver services, receives complaints regarding waiver services	Office of Aging and Adult Services P. O. Box 2031, Bin #14 Baton Rouge, LA 70821-2031 1-866-758-5035
OAAS Regional Offices	Reviews and provides approval of waiver services, monitors support coordination services and offers providers technical assistance	<a href="http://ldh.la.gov/index.cfm/directory/category/141">http://ldh.la.gov/index.cfm/directory/category/141</a>
Gainwell Provider Enrollment Unit	Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer	Gainwell Provider Enrollment Unit P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 or (225) 924-5040 <a href="http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm">http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm</a>
Gainwell Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information and billing issues	Gainwell Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040 <a href="http://www.lamedicaid.com/provweb1/Provider_Support/provider_support_index.htm">http://www.lamedicaid.com/provweb1/Provider_Support/provider_support_index.htm</a>
Statistical Resources, Inc.	Agency to contact regarding CMIS, LaSRS, EVV, and PA Billing Issues	11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501



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## APPENDIX A – CONTACT INFORMATION

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OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
LDH- Health Standards Section	Office to contact to report changes that affect provider license (e.g. Address Change, Change of Ownership, etc.)  Office to contact when providers wish to request an informal hearing as the result of provider's receipt of a statement of deficient practice or file a complaint against a provider by a beneficiary	Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 1-800-660-0488
Division of Administrative Law- LDH Section	Office to contact to request an appeal hearing	Division of Administrative Law 1020 Florida Street Post Office Box 44033 Baton Rouge, LA 70802 Phone: (225) 342-1800 Fax: (225) 342-1813  <a href="https://www.adminlaw.state.la.us/">https://www.adminlaw.state.la.us/</a>
Medicaid Program Integrity	Office to contact to report Medicaid fraud	Provider Fraud Hotline# 1-800-488-2917 Beneficiary Fraud Hotline# 1-888-342-6207 Provider Fraud Fax: (225) 216-6129 Beneficiary Fraud Fax: (225) 389-2610  <a href="http://ldh.la.gov/index.cfm/page/219">http://ldh.la.gov/index.cfm/page/219</a>

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OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Adult Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors	1-800-898-4910
Elderly Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older	1-833-577-6532
Myers and Stauffer LC	Information about filing cost reports and templates	<a href="http://www.mslc.com/Louisiana/HCBS.asp">http://www.mslc.com/Louisiana/HCBS.asp</a>
Adult Day Health Care Resources	Resources containing provider training and/or cost report training	<a href="http://ldh.la.gov/index.cfm/newsroom/detail/1573">http://ldh.la.gov/index.cfm/newsroom/detail/1573</a>
Healthy Louisiana (Medicaid Managed Care Organizations)	Healthy Louisiana (previously called Bayou Health) is the way most of Louisiana's Medicaid and LaCHIP beneficiaries receive health care services. In Healthy Louisiana, Medicaid beneficiaries enroll in a Health Plan	<a href="http://ldh.la.gov/index.cfm/subhome/6">http://ldh.la.gov/index.cfm/subhome/6</a>

## CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

## APPENDIX B – FORMS/LINKS

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## FORMS/LINKS

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

Form/Document/Website Name	Website Address
Rights and Responsibilities for Applicants/Participants of Home and Community Based Services (HCBS) Waivers	<a href="http://ldh.la.gov/assets/docs/OAAS/publications/RightsRespon_Waivers.pdf">http://ldh.la.gov/assets/docs/OAAS/publications/RightsRespon_Waivers.pdf</a>
Transition Services Form (TSF)	<a href="http://ldh.la.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf">http://ldh.la.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf</a>
Emergency Plan	<a href="http://ldh.la.gov/assets/docs/OAAS/EmergencyPrep/EmergencyPlanandAgreementForm.pdf">http://ldh.la.gov/assets/docs/OAAS/EmergencyPrep/EmergencyPlanandAgreementForm.pdf</a>
Electronic Visit Verification (EVV)	<a href="http://ldh.la.gov/index.cfm/page/2751">http://ldh.la.gov/index.cfm/page/2751</a>
OAAS Critical Incident Reporting Webpage	<a href="http://www.ldh.la.gov/index.cfm/newsroom/detail/1418?uuid=1295548571800">http://www.ldh.la.gov/index.cfm/newsroom/detail/1418?uuid=1295548571800</a>
Request for Payment/Override Form	<a href="http://ldh.la.gov/assets/docs/OAAS/publications/Forms/Request-for-Payment-Override-Form.pdf">http://ldh.la.gov/assets/docs/OAAS/publications/Forms/Request-for-Payment-Override-Form.pdf</a>
Support Coordination Monitoring Policy and Procedures Manual	<a href="http://www.ldh.la.gov/assets/docs/OAAS/Manuals/Support-Coordination-Monitoring-Policy-Procedures.pdf">http://www.ldh.la.gov/assets/docs/OAAS/Manuals/Support-Coordination-Monitoring-Policy-Procedures.pdf</a>
Waiver Procedures Manual	<a href="http://ldh.louisiana.gov/index.cfm/newsroom/detail/2923">http://ldh.louisiana.gov/index.cfm/newsroom/detail/2923</a>
Support Coordination Transfer of Records Form	<a href="http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Support-Coordination-Transfer-of-Records-Form.pdf">http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Support-Coordination-Transfer-of-Records-Form.pdf</a>
Louisiana State Adverse Actions List Search and Office of the Inspector General	<a href="https://adverseactions.ldh.la.gov/SelSearch">https://adverseactions.ldh.la.gov/SelSearch</a> <a href="https://exclusions.oig.hhs.gov/">https://exclusions.oig.hhs.gov/</a>

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Form/Document/Website Name	Website Address
Federal System Award Management	<a href="https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf">https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf</a>
Medicaid Services Chart	<a href="http://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf">http://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf</a>

**BILLING CODES**

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

[https://www.lamedicaid.com/provweb1/fee\\_schedules/ADHC\\_Billing\\_Codes\\_Current.pdf](https://www.lamedicaid.com/provweb1/fee_schedules/ADHC_Billing_Codes_Current.pdf)

## GLOSSARY

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

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

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

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

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

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

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

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

**Agency** – An entity which delivers Medicaid support coordination services under an agreement

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CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

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with LDH/OAAS.

**Allegation of non-compliance** – A claim that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a beneficiary or beneficiaries. (La. R.S. 40:2009.14)

**Allowable Cost** – Those expenses incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs.

**Appeal** – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination. A legal proceeding in which the applicant/enrollee and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer. (See Fair Hearing).

**Applicant** – An individual who is requesting Medicaid Waiver services.

**Assessment** – One or more processes that are used to obtain information about an individual, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual meets nursing facility level of care and requires waiver services. The results are used to develop the Plan of Care and an Individualized Service Plan.

**Beneficiary** – An individual who has been certified for Adult Day Health Care through a Medicaid Waiver program. A beneficiary may also be referred to as a participant.

**Bureau of Health Services Financing (BHSF)** – The Bureau within the Louisiana Department of Health is responsible for the administration of the Medicaid program and is the administering agency for the OAAS Waiver programs.

**Case Management** – (See Support Coordination).

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

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

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

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

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

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

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

**Direct Care Staff** – Unlicensed staff paid to provide personal care or other direct service and support to qualified waiver beneficiary’s to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

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

**Eligibility** – The determination of whether or not a beneficiary qualifies to receive waiver services based on meeting established criteria as set by LDH.

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

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

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

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



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**Fiscal Intermediary** – The contractor, managed by Medicaid, which processes claims, issues payments to providers and agencies, handles provider inquiries and complaints, provides training for providers.

**Follow-Up** – A core element of service delivery to the beneficiary that includes oversight and monitoring of the provision of services, ongoing assessment and mitigation of health, behavioral and personal safety risk, and crisis management.

**Formal Services** – Another term for professional and paid services.

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

**Health Standards Section (HSS)** – A section of the Louisiana Department of Health responsible for the licensure and enforcement of compliance of those health care providers licensed by the Health Standards Section.

**Home and Community-Based Services Waiver** – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the beneficiary’s home or community as an alternative to institutional services to individuals who meet nursing facility level of care. Waiver services are approved by CMS and are limited to serving a specific number of individuals in accordance with the approved and available waiver opportunities.

**Individualized Service Plan (ISP)** – An individualized written plan of action to be completed and followed by the ADHC center to address the beneficiary’s difficulties, health care needs, and services based upon his/her assessment.

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

**Institutionalization** – Placement of a beneficiary in any inpatient facility including, but not limited to a hospital, nursing facility, or psychiatric hospital.

**Legal Guardian** – A person who has been granted custody of an individual by a court order.

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

**Licensure** – A determination by the Health Standards Section that a provider meets the requirements of State law to provide health care and services.

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**Linkage** – Act of connecting a beneficiary to a specific support coordination agency or a provider.

**Long Term-Personal Care Services (LT-PCS)** – A Medicaid state plan service which provides assistance with ADL and IADL as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older and meet specific program requirements.

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

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

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

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

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

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

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

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

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

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**Office of Aging and Adult Services (OAAS)** – The office within the Louisiana Department of Health that is responsible for the management and oversight of certain Medicaid home and community-based services waiver programs, state plan programs, adult protective services for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

**OAAS Regional Office** – One of nine administrative offices within the Office of Aging and Adult Services.

**Office of Behavioral Health (OBH)** – The office in LDH that is responsible for services to individuals with behavioral or addictive disorders.

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

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

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

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

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

**Program of All-Inclusive Care for the Elderly (PACE)** – Program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified beneficiaries age 55 and older in order to enhance their quality of life and allow them to continue to live in the community.

**Progress Notes** – Documentation of the delivery of services, activities and observations of a beneficiary to record progress toward the goals indicated in the POC and/or ISP.

**Provider** – An entity which delivers Medicaid services under a provider agreement with LDH.

**Provider Agreement** – A contract between the provider of services and the Medicaid program or

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other LDH office. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other LDH office.

**Provider Enrollment** – See “Enrollment”.

**Re-assessment** – See “Assessment”. The re-assessment is completed at least annually for waiver beneficiaries and when a significant status change occurs in order to update the POC and/or ISP.

**Registered Nurse (RN)** – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

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

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

**Request for Services Registry (RFSR)** – A waiting list for the ADHC Waiver program which contains the names and dates of requests of individuals applying for an ADHC Waiver opportunity.

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

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

**Support Coordination** – Services provided to eligible beneficiaries to help them gain access to the full range of needed services including medical, social, educational, housing, and other support services regardless of the funding source for these services. Activities also include assessment, Plan of Care development, service monitoring, critical incident management, and

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transition/discharge.

**Support Coordinator** – An individual who meets the required qualifications and who is employed by a Support Coordination Agency.

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

**Waiver Opportunity** – An offer made to an individual on the ADHC Waiver Request for Services Registry. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.

## CLAIMS RELATED INFORMATION

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

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

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

Paper claims should be submitted to:

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

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

This appendix includes the following:

1. Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and
2. Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

### CMS 1500 (02/12) Instructions for Waiver Services

In order to access the CMS 1500 (02/12) Instructions for Waiver Services and to view sample forms, use the following link:

[https://www.lamedicaid.com/Provweb1/billing\\_information/CMS\\_1500.htm](https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500.htm).

**NOTE:** You must write “WAIVER” at the top center of the claim form.

### ADJUSTING/VOIDING CLAIMS

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

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

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

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

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

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

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

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

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CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

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## APPENDIX E – CLAIMS RELATED INFORMATION

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

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

**Adjustments/Voids Appearing on the Remittance Advice**

When an Adjustment/Void Form has been processed, it will appear on the 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.

Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website below for general information concerning topics relative to general claims filing. To access the General Information and Administration Provider Manual chapter, click here:  
<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>.

**Sample forms are on the following pages.**



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## SAMPLE WAIVER CLAIM FORM ADJUSTMENT



# WAIVER

Mail completed form to:  
**Gainwell Technologies**  
**P.O. Box 91020**  
**Baton Rouge, LA 70821**

## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICAID <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRI-CARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (TRICARE) (Member ID#) (ID#) (ID#) (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>9876543210123</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Jayco, Travis</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE <b>07 31 72</b>		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. RESERVED FOR NUCC USE		9. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH MM DD YY M SEX F	
12. INSURED'S DATE OF BIRTH MM DD YY M SEX F		13. OTHER CLAIM ID (Designated by NUCC)	
13. OTHER CLAIM ID (Designated by NUCC)		14. INSURANCE PLAN NAME OR PROGRAM NAME	
14. INSURANCE PLAN NAME OR PROGRAM NAME		15. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
15. IS THERE ANOTHER HEALTH BENEFIT PLAN?		16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)		17. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)	
17. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)		18. OTHER DATE	
18. OTHER DATE		19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		21. OUTSIDE LAB?	
21. OUTSIDE LAB?		22. RESUBMISSION CODE	
22. RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER	
23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE	
24. A. DATE(S) OF SERVICE		24. B. PLACE OF SERVICE	
24. B. PLACE OF SERVICE		24. C. EMG	
24. C. EMG		24. D. PROCEDURES, SERVICES, OR SUPPLIES	
24. D. PROCEDURES, SERVICES, OR SUPPLIES		24. E. DIAGNOSIS	
24. E. DIAGNOSIS		24. F. CHARGES	
24. F. CHARGES		24. G. DATES	
24. G. DATES		24. H. PROCT	
24. H. PROCT		24. I. ID. QUAL	
24. I. ID. QUAL		24. J. RENDERING PROVIDER ID. #	
24. J. RENDERING PROVIDER ID. #		25. FEDERAL TAX I.D. NUMBER	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.	
26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT?	
27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE	
28. TOTAL CHARGE		29. AMOUNT PAID	
29. AMOUNT PAID		30. Rvd for NUCC Use	
30. Rvd for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#	
33. BILLING PROVIDER INFO & PH#		34. HERE FOR YOU WAIVER	
34. HERE FOR YOU WAIVER		35. ANY TOWN, LA 70000	
35. ANY TOWN, LA 70000		36. a. 1234509876	
36. a. 1234509876		36. b. 1123456	

NUCC Instruction Manual available at: www.nucc.org

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## CHAPTER 9: ADULT DAY HEALTH CARE WAIVER

## APPENDIX E – CLAIMS RELATED INFORMATION

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## SAMPLE CLAIM FORM



## HEALTH INSURANCE CLAIM FORM

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

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BOX LUNG OTHER (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M F									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other									
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										8. RESERVED FOR NUCC USE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO 10d. CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER										12. INSURED'S DATE OF BIRTH MM DD YY SEX M F									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.									
15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. QUAL. 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS ON UNITS H. FIRST (Only) Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER									
1										NPI									
2										NPI									
3										NPI									
4										NPI									
5										NPI									
6										NPI									
25. FEDERAL TAX I.D. NUMBER SBN EIN										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? YES NO										28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Paid for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # ( )										34. BILLING PROVIDER INFO & PH # ( )									
SIGNED DATE										SIGNED DATE									

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**CONCURRENT SERVICES**

Waiver services that are available while a beneficiary is in a hospital or in a nursing facility are considered concurrent services. Some Adult Day Health Care (ADHC) Waiver services are payable when a beneficiary is in a hospital or nursing facility. All services must be prior approved as indicated in Section 9.1 – Covered Services.

The following ADHC Waiver services are payable when a beneficiary who has been receiving ADHC Waiver services has a temporary stay in a hospital or a nursing facility or when a beneficiary is transitioning from a nursing facility to the community:

**Payable Waiver Services During a Temporary Stay in a Nursing Facility or Hospital**

1. Support Coordination.

**Payable Waiver Services When Transitioning from a Nursing Facility to the Community**

1. Transition Intensive Support Coordination; and
2. Transition Services.