DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Community Supports and Services

Elderly and Disabled Adult Waiver

Direct Service Provider Manual

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ELDERLY AND DISABLED ADULT WAIVER

The Elderly and Disabled Adult (EDA) Waiver is a Medicaid Home and Community-based Services Waiver providing alternative services to individuals which allows them to live in the community instead of a Nursing Home or Institution.

This provider manual specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of Federal and State laws and Department of Health and Hospitals (DHH) policy which provide support to such 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 material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This manual is intended to provide an EDA waiver provider with the information necessary to fulfill its vendor contract with the State of Louisiana, and is the basis for Federal and State reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with Federal and State laws and Department rules.

The Department of Health and Hospitals, Bureau of Community Supports and Services (BCSS) is responsible for assuring provider compliance with these regulations and for the licensing of case management agencies.

The Licensing and Certification Division of the Department of Social Services determines compliance with State licensing requirements for Personal Care Attendant services to be provided as specified in the approved Comprehensive Plan of Care (CPOC).

Waiver services to be provided are specified in the CPOC formulated by the Interdisciplinary Team of the case management agency and approved by the BCSS. The plan of care contains all services and activities involving the recipient, non-waiver as well as waiver services. Recipients are to receive only those waiver services included in the CPOC and approved by the BCSS office. Notification that services are approved is forwarded to the provider on Form MR/DD 14 by the case manager.

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 federal Health Care Financing Administration.

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GENERAL MEDICAID INFORMATION

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WHAT IS MEDICAID?

Medicaid is a joint federal-state program enacted by Title XIX of the Social Security Act and governed by the regulations contained in Title 42 of the Code of Federal Regulations. The Center for Medicare and Medicaid (formerly known as Health Care Financing Administration HCFA) sets the guidelines for the states' participation in Medicaid and monitors the different state programs. The Louisiana Department of Health and Hospitals (the Department), Bureau of Health Services Financing (the Bureau) determines policies for complying with state laws and federal guidelines and is the designated state agency responsible for administering the program. The Louisiana Medicaid Program is designed to provide certain health care benefits for those *categorically needy* and *medically needy recipients* who are in need of medical services. This means-tested program has federal guidelines that place requirements on states for coverage of specific groups of people and benefits. To be eligible for Federal funds, states are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as related groups not receiving cash payment. These are called mandatory eligibility groups. States also have the option to provide Medicaid coverage for other "categorically needy"groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are defined more liberally. The Medicaid system provides state and federal funds for health professionals who perform and/or deliver medically necessary services and/or supplies for Medicaid recipients

COMPONENTS OF MEDICAID

THE PROVIDER

The provider's role is to provide health care services or supplies to Medicaid eligible recipients. To receive reimbursement for services, the provider must be an enrolled Medicaid provider and agree to abide by all applicable federal laws and regulations, state laws, rules and regulations and Department policies and practices established by the program, and adequately document the necessity for and the services or supplies provided to the recipient.

THE RECIPIENTS

Determining eligibility for Medicaid is the responsibility of the Bureau, who in turn informs the fiscal intermediary of eligible recipients. Recipients fall into two classifications: Categorically and Medically Needy.

THE MEDICAID CARD

All recipients will be issued a Medicaid Card. This card serves as a notice to recipients of their eligibility for Medicaid and identifies eligible recipients to providers of medical care services.

BUREAU RESPONSIBILITY

The Bureau is responsible for the overall management of the Medicaid program, including the following functions:

- Administering the program including developing rules, regulation, and policies relative to the program.
- Determining the services covered by the program and setting the reimbursement rates within federal guidelines;
- Determining eligibility of recipients, maintaining the recipient eligibility file, and issuing Medicaid cards to eligible recipients;
- Enrolling providers who wish to participate in the program;
- Operating the Medicaid Management Information System (MMIS) and processing claims from providers through its fiscal intermediary;
- Operating an EPSDT tracking system through its contractor.
- Conducting prepayment and post payment review.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

A fiscal intermediary is required to operate an approved Medicaid Management Information System (MMIS) consistent with guidelines established by the Department.

MAJOR OBJECTIVES

MMIS is a claim processing and information retrieval system designed to improve the management and control of Title XIX expenditures. The system is designed to reduce program costs through effective claims processing and utilization control. The major objectives of the system are as follows:

- Improve services to recipients;
- Reduce payment time to providers;
- Provide faster responses to inquiries;
- Improve claims processing efficiency;
- Provide greater utilization of the information databases;
- Improve control and audit trails;
- Improve ability to handle increased claims volume; and,
- Improve ability to handle federal reporting requirements.

ADMINISTRATIVE DUTIES

The fiscal intermediary is also responsible for the following administrative components:

- Processing Claims;
- Set up computer systems designed to Department standards for federal funding for administrative control;

- Computer equipment and program support;
- Management information tools to improve control of the program;
- Provider Relations personnel;
- Pharmacy Benefits Management Program including a drug utilization review program (DUR);
- A Surveillance and Utilization Review Subsystem (SURS) and SURS personnel;
- Recommendations regarding medical policy; and,
- Prior authorization of services.

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ELIGIBILITY

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ELIGIBILITY

Listed below are Medicaid eligibility categories and certain groups that may effect your reimbursement.

Categorically Needy

Recipients classified as Categorically Needy must meet all requirements, including the financial, income, and resource requirements. There is no co-payment from these recipients. All services or equipment billed to the Bureau shall be considered payment in full.

Medically Needy (Types 20, 21, and 25)

Medically Needy recipients may be either, **Regular Medically Needy** or **Spend-down Medically Needy.** Regular Medically Needy recipients are those individuals or families who meet all LIFC (Low-Income Families with Children) related categorical requirements and whose income is within the Medically Needy Income Eligibility Standard (MNIES) and/or whose resources are within the allowable limits.

Spend-down Medically Needy recipients are those non-institutionalized individuals or families whose resources fall within the Medically Needy resource limits, but whose income has been spent down to the MNIES. Spend-down applicants may qualify for the Medically Needy Program on the basis that countable income has been spent or is obligated to pay unpaid medical expenses. Spend-down medically needy eligibility begins on the exact date that medical expense incurred by these recipients allowing them to "spend-down" to the income that will qualify them for Medicaid. These spend-down medically needy recipients are responsible for a co-payment for some expenses.

Any provider who has medical bills from the exact date of the recipient's spend-down will receive a **Spend-down Medically Needy Notice (Form 110-MNP)** from the Bureau. A sample of this form is provided on the following page. This form will notify the provider of the co-payment amount due by the recipient and the amount to be billed to Medicaid. *The provider must attach this form to the claim and submit the claim manually to the fiscal intermediary for processing.* The provider cannot bill the recipient for any amount over the amount specified on the Form 110-MNP under Recipient Liability.

Service restrictions apply to Medically Needy benefits and eligibility for service coverage should be verified.

The following services are **not** covered in the Medically Needy Program:

Adult Dental service or dentures
Alcohol & Substance Abuse Clinic/Services
Mental Health Clinic Services
Home and Community Based Waiver Services
Home Health (Nurse Aid and Physical Therapy)
Case Management Services
Mental Health Rehabilitation Services
Psychiatric Inpatient Services for individuals under 22 years of age
Sexually Transmitted Diseases (STD) Clinic services, and
Tuberculosis (TB) Clinic services

Medically Needy Recipients are identified on the MEVS and REVS systems. MEVS and REVs denote the appropriate eligibility information based on the provider type of the inquiring provider. RECIPIENTS ELIGIBLE THROUGH PROGRAMS OTHER THAN THE MEDICALLY NEEDY PROGRAM ARE NOT AFFECTED. Recipients with questions should be advised to direct inquiries to the Bureau's Eligibility Operations Section at (888) 342-6207. Providers with inquiries a should call Unisys Provider Relations at (800) 473-2783 or (226) 924-5040.

There are several eligibility groups that an individual will may qualify for under the broad categories listed above.

ELIGIBILITY GROUPS

ILLEGAL ALIENS

These individuals are certified only for limited periods of eligibility via Form 18-EMS. Their days of eligibility only cover dates of service on which emergency services were rendered. Once a person's eligibility ceases, he/she must re-apply at the parish office if coverage for new emergency services is to be granted.

PRESUMPTIVE ELIGIBILITY

Pregnant women may have "Presumptive Eligibility (PE)" determined by a "qualified provider"such as a state hospital or public health unit. Presumptive eligibility begins on the date the qualified provider determines the pregnant woman eligible and, if the recipient has not filed an application for Medicaid, ends the last day of the following month. If a Medicaid application is filed the woman will remain PE until the eligibility on the pregnant woman

application is rendered. During this period the "presumptively eligible" pregnant women will be eligible for ambulatory (outpatient) prenatal care including non-emergency transportation. Coverage may expire at any time if eligibility requirements are not met. MEVS and REVS eligibility verification responses will alert providers that the recipients may be eligible for outpatient ambulatory services only and that providers must inquire to verify eligibility. **Verification should be made by calling the following number (800) 834-3333.**

QUALIFIED MEDICARE BENEFICIARY (QMB)

Recipients classified as Qualified Medicare Beneficiary (QMB) have enrolled or conditionally enrolled in Medicare Part A (Medicare Hospital Insurance) and met the income and resource requirements for Medicaid eligibility for QMB. QMB recipients may be either:

Pure QMB—recipients eligible for Medicaid payment only for QMB services that include:

- Medicare Part A and B premiums
- Medicare deductibles for Medicare covered services
- Medicare co-insurance for Medicare covered services.

If the services are not covered by Medicare, Medicaid will also not provide reimbursement for these services.

Pure QMB recipients are identified by information obtained through the automated eligibility systems.

- Dual QMB—recipients eligible for the same benefits as Pure QMB plus the full range of **Medicaid covered services** in any other category of assistance. These recipients are identified by information obtained through the automated eligibility systems.

EPSDT RECIPIENTS

EPSDT recipients are eligible for DME equipment and supplies for recipients under the age of twenty-one (21).

COMMUNITYCARE PROGRAM

CommunityCARE is a primary care case management (PCCM). The program provides Medicaid recipients under age 65 in designated parishes with a primary care physician (PCP) who serves as the recipient's family doctor. The PCP provides basic primary care, referral, and after hours coverage of medical services for each recipient. The PCP receives a small monthly management fee for recipients assigned to him/her in addition to fee-for-service reimbursement for medical services rendered.

CommunityCARE recipients receive a Medicaid card which will be issued for each eligible person in a household. Each eligible recipient in a household may select or be assigned to a different CommunityCARE provider. Only the physician shown in REVS or MEVS, as the CommunityCARE PCP, is authorized to provide services or make referrals for that recipient.

VERIFYING ELIGIBILITY

MEDICAID ELIGIBILITY VERIFICATION SYSTEM (MEVS)

MEVS is an electronic system used to verify Medicaid recipient eligibility and third party liability. This information can be accessed through personal computer (PC) software, "swipe card device" or computer terminal. This system is available seven (7) days per week, 24 hours per day with occasional short maintenance periods. Providers will access MEVS by contracting with telecommunications vendors ("Switch Vendors"), who will provide a magnetic card reader, PC software, or a computer terminal necessary for system access.

RECIPIENT ELIGIBILITY VERIFICATION SYSTEM (REVS)

REVS is a telephonic system used to verify Medicaid recipient eligibility. It is available seven (7) days a week, 24 hours per day (except for short maintenance periods). The system provides basic eligibility, service limits and restrictions, TPL, and program eligibility information. This system is accessible through touch-tone telephone equipment using Unisys tool-free telephone number (800) 776-6323.

MEVS AND REVS ACCESS DATA

Any two of the following pieces of information may be used to access the system and receive eligibility information from MEVS or REVS:

Recipient card control number and issue date
Recipient name
Recipient ID number
Recipient date of birth

Recipient social security number

MEVS AND REVS REMINDERS

The following areas may potentially cause problem responses through both MEVS and REVS:

A valid eight-digit date of birth must be entered when using REVS or MEVS.

Eight-digit dates must be used when entering any dates through either system.

You must listen to the menu and press the appropriate keys to obtain CommunityCARE or Lock-In Information through REVS.

When using a recipient 13 digit Medicaid number, remember that both systems carry only recipient numbers which are valid for the last 12 months. If you are entering an old number (valid prior to the last 12 months), you will receive a response which indicates the recipient is not on file.

When using a 13-digit Medicaid number or a 16 digit Card Control Number for you inquiry into either system, you will receive the most current , valid 13-digit Medicaid number as part of the eligibility response.

Claims must be filed with the 13-digit Medicaid identification number.

Every effort is being made to ensure that all recipients' dates of birth are accurate on the Medicaid file. A REVS or MEVS reply of "recipient not on file" may be the result of an incorrect recipient date of birth on Medicaid State files. In this situation, the provider should refer the recipient to either his Parish Office or call (800) 834-3333 to correct the error.

MEDICAID CARD

A plastic Health Network of Louisiana swipe card is now issued to each eligible recipient by Department of Health and Hospitals. Each Medicaid recipient is issued a card with a unique identifying number. Eligibility information for that recipient, including third party liability and any restrictions, may be obtained by accessing information through the Medical Eligibility Verification System (MEVS), or telephoning the Recipient Eligibility Verification System (REVS) at 1-800-766-6323.

For All Presumptive Eligibility (PE) recipients, call 1-800-766-6323 to verify PE eligibility or if there is any problem with the information received when swiping the Medicaid card.

This is an example of the plastic Health Network of Louisiana card issued by the fiscal intermediary.

SECTION 3
PROVIDER RESPONSIBILITIES

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PROVIDER RESPONSIBILITIES

INTRODUCTION

Provider participation in the Louisiana Medicaid program is voluntary. When a provider enrolls in the Medicaid program, he/she agrees to abide by all rules and regulations established by the Bureau, HCFA, and Federal and State governments.

CHANGE OF ADDRESS/ENROLLMENT STATUS

It is the responsibility of the provider to notify the Provider Enrollment Section at:

UNISYS
Provider Enrollment
P. O. Box 80159
Baton Rouge, LA 70898-0159

Of the following changes in the operating status:

- Any change in physical location,
- Any change in mailing address,
- Any change in telephone number,
- Any change in ownership, and
- Any change in account information affecting EFT.

CHANGE IN OWNERSHIP (CHOW)

A change in ownership (CHOW) occurs whenever 5% or more of the controlling interest occurs. The provider must notify the Bureau's Provider Enrollment Unit at (225) 923-8510 or the address above or when such a change occurs. A CHOW requires a new provider enrollment packet be completed.

MEDICAL ASSISTANCE PROGRAM INTEGRITY LAW (MAPIL)

It is the provider's responsibility to be knowledgeable of all these terms and conditions in MAPIL and in the provider agreement.
MAPIL became effective August 15, 1997, and is cited as LSA RS 46:437.1-46: 440.3. It statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into the agreement.

Terms and conditions imposed on the provider by MAPIL include but not limited to the following:

- Comply with all federal and state laws and regulations;
- Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- Have all necessary and required licenses or certificates;
- Maintain and retain all records for a period of five (5) years;
- Allow for inspection of all records by governmental authorities;
- Safeguard against disclosure of information in patient medical records;
- Bill other insurers and third parties prior to billing Medicaid;
- Report and refund any and all overpayments;
- Accept payment in full for Medicaid recipients providing allowances for co-payments authorized by Medicaid;
- Agree to be subject to claims review;
- The buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- Notification prior to any change in ownership;
- Inspection of facilities; and,
- Posting of bond or letter of credit when required.

The Bureau's Provider Enrollment section may terminate a providers enrollment for failure to comply with MAPIL terms or other Medicaid policies.

STANDARDS FOR PROVIDER PARTICIPATION

Provider participation in the Medicaid program is voluntary. State laws, rules and regulations, department policies and practices and federal laws define certain standards for participating providers. These standards include but are not limited to the following
Provider agreement and enrollment with the Bureau;

- Agreement to Electronic Funds Transfer (EFT), also known as direct deposit, of Medical provider payments.

- Agreement to charge Medicaid no more for services furnished eligible recipients than is charged on the average for similar services to others;

- Agreement to accept as payment in full the amounts established by the Bureau and not to seek additional payment from the recipient for any unpaid portion of a bill; except in cases of Spend-Down Medically Needy recipients;

- Agreement to maintain medical records, all Remittance Advices, and any information regarding payments claimed by the provider for furnishing services; and,

- Agreement that all services to and materials for recipients of public assistance be in compliance with Title VI of the ***1964 Civil Rights Act***, Section 504 of the ***Rehabilitation Act of 1973***, and, where applicable, Title VII of the ***1964 Civil Rights Act***.

- **Records retention for five (5) years** and furnishing records as requested, to the Bureau, its authorized representative, representatives of DHH's or the state Attorney General's Medicaid Fraud Control Unit.

It is the provider's responsibility to know and comply with policies regarding provider participation.

INDICATION OF AGREEMENT

Although this is a voluntary program, providers should note that their signature on a claim form will serve as their agreement to abide by all policies and regulations of the Louisiana Medicaid Program. This agreement also certifies that, to the best of the provider's knowledge, information contained on the claim form is true, accurate, and complete.

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RECIPIENT RIGHTS AND RESPONSIBILITIES

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RECIPIENT RIGHTS AND RESPONSIBILITIES

In addition to the rights and responsibilities available to citizens of this state and country, there are specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs. Case managers and service providers must assist recipients to exercise their rights and responsibilities. Every effort must be made to assure that applicants or recipients understand their available choices and the consequences of those choices. Case managers and service providers are bound by their provider agreement with Medicaid to adhere to the following policies on recipient rights.

FREEDOM OF CHOICE OF PROGRAM

Applicants/recipients requesting services who qualify as being in need of the level of care provided by a nursing facility have the freedom to select between the institutional care services and community-based services. Applicants/recipients have the responsibility to participate in the evaluation process. This includes providing the medical and other pertinent information or assisting in obtaining it for use in the person-centered planning process and certification for services. When applicants are admitted to the waiver, they have access to an array of Medicaid services. This voluntary program is available upon request and specific eligibility criteria apply.

NOTIFICATION OF CHANGES

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

The DHH Bureau of Community Supports and Services (BCSS) is responsible for approving level of care and medical certification. In order to maintain this certification, recipients have the responsibility to inform the BCSS, through their case manager, of any significant changes which will affect their service needs. Neither case managers nor service providers may approve or deny eligibility for the waiver.

FREEDOM OF CHOICE OF CASE MANAGER AND SERVICE PROVIDER

At the time of admission to the waiver, and every six months thereafter, recipients have the opportunity to change case management providers, if one is available. Notices will be sent to the recipients every six months explaining the process to change case management providers and help arrange for the service included in the CPOC. Case managers will

provide recipients their choice of direct service providers and help arrange and coordinate the services on the comprehensive plan of care.

Freedom of Choice of Case Management at Admission

The point of entry for the EDA waiver is the local Councils on Aging (COA). The local COA locates the next person on the waiting list by sending a letter of notification to the potential waiver applicant. The applicant must respond to the COA if he/she desires or denies waiver services.

At the time of application, the COA offers the individual a Freedom of Choice (FOC) form to select a case management agency and assists/instructs them to fax or mail the completed form to the BCSS Contractor for linkage to a case management agency.

The BCSS contractor notifies the case management agency of the linkage. A case manager then visits the applicant in his/her home to start the application process and assessments for the EDA waiver.

Freedom of Choice of Direct Service Provider

The FOC form to select a direct service provider is offered and facilitated by the case manager. The case manager will meet with the applicant and or family to review the EDA waiver program and the FOC for a direct service provider.

Once a choice is made by the applicant, the case manager will notify the direct service provider to coordinate a team meeting to formulate a comprehensive plan of care reflecting the needed services. Members of the team meeting should include the applicant/recipient, potential direct service provider(s), case manager, medical and social work professionals (i.e., home health nurse) as necessary, and family members or other individuals who support the applicant/recipient.

The direct service provider agency must be licensed by the State of Louisiana, Department of Social Services (DSS) and be currently enrolled as a Medicaid provider on the FOC list. Provider participation in the Louisiana Medicaid program is voluntary. When the provider enrolls in the Medicaid program, he/she agrees to abide by all rules and regulations established by the DHH Bureau of Health Service Financing, the Center for Medicare and Medicaid (CMS) formerly known as HCFA, and federal and state requirements. The signature on the Provider Enrollment form and claim forms serves as the agency's agreement to abide by all policies and regulations of the Louisiana Medicaid Program. (See Provider Responsibility Section)

DSS Licensing information may be obtained by contacting:

Department of Social Services
Bureau of Licensing
P.O. Box 3078
Baton Rouge, La 70821-3078
Phone # (225) 922- 0015

PARTICIPATION IN CARE

Each recipient shall participate in a person-centered planning meeting and any other meeting involving decisions about services and supports to be provided as part of the waiver process. Person-centered planning will be utilized in developing all services and supports to met the recipient's needs. By taking an active part in planning his/her services, the recipient is better able to utilize the available supports and services. The recipient shall report any service need change to his/her case manager and service provider(s).

Changes in the amount of services must be requested by the case manager at least 15 days before taking effect except in emergencies. These changes must be approved by the BCSS Regional Office. Direct service providers may not initiate requests for change of service or modify the CPOC without the participation and consent of the recipient.

VOLUNTARY PARTICIPATION

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

QUALITY OF CARE

Each recipient of home and community-based waiver services has the right to receive services from provider agency employees who have been trained and are qualified to provide them. In cases where services are not delivered according to the approved CPOC or there is abuse or neglect on the part of the service provider, the recipient shall follow the complaint reporting procedure and cooperate in the investigation and resolution of the complaint. Recipients may not request providers to perform tasks that are illegal or inappropriate, and they may not violate the rights of providers.

CIVIL RIGHTS

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

ADEQUACY OF CARE

All recipients in Louisiana's home and community-based waiver programs have the right to choose and receive the services necessary to support them to live in a community setting. Services are arranged and coordinated through the case management system and approval by the BCSS Regional Office staff. Administrative limits are placed on some services according to the waiver that is authorized by CMS.

Recipients have the responsibility to request only those services they need and not request excess services, or services for the convenience of providers or case managers. Units of service are not "saved up". The services are certified as medically necessary and are revised on the comprehensive plan of care as each recipient's needs change.

GRIEVANCES/FAIR HEARINGS

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

Each case management/direct service provider shall have grievance procedures through which recipients may grieve the supports or services they receive. The provider shall

advise recipients of this right and of their rights to a fair hearing and the process for an appeal through the Medicaid program. In the event of a fair hearing, a representative of the service provider and case management agency shall appear and participate in the proceedings.

An appeal by the recipient may be filed at the local Medicaid Office or the DHH Appeal Section. The address for DHH Appeals is:

DHH Appeals Section
P.O. Box 4183
Baton Rouge, LA 70821-4183

COMPLAINT/HELP LINE

The BCSS has a toll-free number (1-800-660-0488) to provide waiver assistance, clarification of waiver services, and reporting complaints regarding waiver services including reports of abuse, neglect and exploitation.

This toll-free number is accessible within the state of Louisiana.

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COVERED SERVICES

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PERSONAL CARE ATTENDANT SERVICES

The EDA Waiver provides personal care attendant (PCA)services to waiver recipients according to the approved Comprehensive Plan of Care (CPOC). PCA services are those services provided by a state licensed PCA agency whose employees have been trained to meet the needs of waiver recipients requiring assistance with certain skills related to the activities of daily living, such as bathing, dressing, grooming, food preparation and storage of food. The necessity for PCA services shall be documented on the CPOC by identifying an unmet need requiring assistance. For those recipients living with their families, PCA services shall be provided in the home in the presence or absence of the family member who is the usual care giver. Services shall only be provided to recipients of waiver services.

One PCA may provide care to more than one EDA waiver recipient requiring PCA services when those recipients live in the same home. The PCA must provide care to each individual as per the CPOC, and that care must be reflected on the PCA's time sheet. The PCA agency shall only bill for actual hours of service worked. If the PCA worked for two recipients in the same home for a total of four hours, the PCA agency can only bill for four hours of service. They shall not bill for eight hours of service.

The PCA provider is responsible for informing the case manager of any changes in the recipient's condition or service needs.

DESCRIPTION OF SERVICES

Personal care services are divided into four different services that are available to the recipients in the EDA waiver. Any of the four personal care services are to be made available as a choice for those waiver recipients who demonstrate an inability or impairment to perform their self-care activities, general household tasks, or reside alone without assistance. These services must be incorporated in the approved CPOC and documented on the recipient's progress notes by the PCA.

Employees of the PCA provider agency may provide all four types of personal care services to the recipient according to the approved CPOC. PCA services to recipients that are reimbursed under this waiver shall include any of the following services.

Personal Care Attendant

PCA service is assistance with eating, bathing, dressing, personal hygiene, activities of daily living and services needed to maintain the health and welfare of the recipient. PCA services incude:

- Assisting with personal hygiene, dressing, bathing and grooming;
- Assisting with bladder and/or bowel requirements or problems, including help with bed pan routines.

Note: Non-complex nursing tasks must be provided under the delegation and supervision of a registered nurse or the delegation of a physician who accepts liability in writing for the performance of the task.

Note: Complex nursing tasks must be provided under the delegation of a licensed physician who accepts liability for the performance of the task.

Household Supports

Household Supports consist of general household activities and supports (meal preparation and routine household care) and may include general household cleaning. Household Supports is provided by the PCA worker who is trained to provide homemaker assistance. Household Supports includes:

- Performing or assisting in the performance of tasks related to maintaining a safe, healthy and stable living environment such as light cleaning tasks which should only be in areas of the home used exclusively by the recipient, or those parts of common areas used by the recipient;
- Performing more extensive cleaning chores for those recipients living alone who need supports for all cleaning tasks;
- Shopping for such items as health and hygienic products, clothing and groceries, etc.

Day Supervision

Day Supervision is non-medical supervision and socialization provided to a functionally impaired adult when the recipient is usually awake. Day supervision attendants may assist or supervise the recipient with such tasks as meal preparation, laundry, and shopping.

Day Supervision is provided by the PCA worker for waiver recipients who are unable to safely stay alone, self-direct their own care, or self- preserve and/or evacuate in dangerous situations. These services are non-medical and are defined as a supervision companion. Day Supervision services include:

- Performing or assisting with daily living activities in the home;
- Assisting recipients in dangerous situations by helping them evacuate from either their residence or, if appropriate, from the geographic area as indicated on the evacuation plan in the CPOC;
- Assisting the recipient in transfer and/or ambulation in those activities which are necessary to live independently;
- Assisting in the storage of foods and the preparation and eating of meals;
- If indicated, accompanying recipients to clinics, physicians' offices, and appointments related to receiving or maintaining benefits;
- Assisting the recipient to receive any service specified in the approved CPOC, including achieving or maintaining personal outcomes in the areas of identity, autonomy, affiliation, attainment, safeguards, rights and health and wellness;
- Assisting recipients, who are unable to do so without supports, participate in their community according to the personal outcomes included on the CPOC.

Night Supervision

Night Supervision is is non-medical supervision provided during the recipient's night sleep periods. This service is to provide safety for the recipient who lives alone and is limited in mobility or cognitive function to such an extent that he/she may not be able to utilize a Personal Emergency Response System (PERS) or a telephone to preserve his/her own

safety in an emergency situation. Night Supervision may also provide safety for the recipient who is awake and wanders.

Procedure Codes and Rates for Personal Attendant Services (Billed in half hour increments)

SERVICE	PROCEDURE CODE	UNIT OF SERVICE	REIMBURSEMENT RATE
Personal Care	Z0070	½ hour	$5.00
Household Supports	Z0071	½ hour	$4.00
Personal Supervision (Day)	Z0072	½ hour	$3.00
Personal Supervision (Night)	Z0073	½ hour	$2.00

Note: **The cost of the EDA Waiver Services is limited to an average of $ 35.00 a day.** ***Rates as of July 1, 2001.***

PERSONAL CARE AND HOME HEALTH AIDE SERVICES

Recipients of waiver services are also eligible for all other Medicaid services for which there is a medical need.

PCA waiver services are authorized for the recipient by a physician in accordance with a comprehensive plan of care approved by the BCSS. These services are provided to the recipient in his/her home.

The home health aide service is semi-skilled assistance by qualified personnel with activities of daily living provided to the recipient who requires assistance in at least two areas of functioning and monitoring of vital signs, reporting to a professional under a written plan of care, and requiring a clinical note for each visit in accordance with the State Minimum Standards for Licensing of Home Health Agencies(LAC 48:I. Chapter 91).

Home health aid services are not to be provided at the same time and in duplication with the personal care services for the waiver recipient. The personal care services provided should reflect the personal outcomes of the recipient.

LOCATION OF SERVICE DELIVERY

Recipients are to receive services in the home. These services are provided to the individual in his or her own home, or the home of a relative that provides a place of residence, and not as an inpatient or resident of a hospital, nursing facility, or institution

TRANSPORTATION AS PART OF PCA SERVICES

Medicaid non-emergency transportation provides transportation to any Medicaid recipient for medical appointments. The PCA may provide transportation for recipients as part of PCA services. However, **transportation is not required and will not be reimbursed.** If the PCA agency should provide transportation as part of the agency's service, the agency must assure that the PCA worker has a current driver's license and car insurance. In addition, the PCA must accept liability for any transportation that is provided.

ENVIRONMENTAL MODIFICATIONS

Home modifications are those services which assess the need, arrange, and provide for modifications and /or improvements to a recipient's living quarters to enable mobility for community living and ensure safety, security, and accessibility. Necessary physical adaptations to the home are to be requested by the recipient, documented on the comprehensive plan of care and must be approved by the BCSS Regional Office prior to the environmental modification service being provided. Housing modification services consist of the following:

- Ramps
- Lifts
  - Porch or stair lifts
  - Hydraulic, manual, or other electronic lifts
- Modifications/additions of bathroom facilities
  - Roll-showers
  - Sink modifications
  - Bathtub modifications
  - Toilet modifications
  - Water faucet controls

- Floor urinal and bidet adaptions
- Plumbing modifications
- Turnaround space adaptations

- Specialized accessibility/safety adaptations/additions
  - Door widening
  - Electrical wiring
  - Grab bars and handrails
  - Automatic door openers/doorbells
  - Voice activated, light activated, motion activated and electronic devices
  - Fire safety adaptations
  - Medically necessary air filtering devices
  - Medically necessary heating/cooling adaptions
  - Other modifications to the home necessary for medical or personal safety.

STANDARDS

All providers must meet all state and/or local requirements for licensure or certification (such as building contractors, plumbers, electricians, or engineers). Providers must enroll as a Medicaid Environmental Modifications providers and file claims on HCFA Form 1500.

All modifications, improvements, or repairs must be made in accordance with all local and state housing and building codes, and must meet ADA requirements.

EXCLUSIONS

General house repairs are not included, but repairs to housing modifications are allowed as necessary if identified in the approved plan of care. Adaptations or improvements which are not of direct medical or remedial benefits to the recipient, such as carpeting, roof repair, central air condition, etc. are excluded. Home modification funds are not intended to cover basic construction costs. For example, in a new facility, a bathroom is already part of the building costs. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

Only those adaptations or improvements not available as a Durable Medical Equipment (DME) device may be authorized. Some lifts, filters, etc., may be covered as a DME item.

The case manager shall explore the possibility by contacting the Unisys DME Prior Authorization Unit at (800) 488-6334 or (225) 928-5263.

MEDICAL NECESSITY

A doctor's statement concerning medical necessity for air filtering advices and heating/cooling adaptations is required. The case manager shall obtain such documentation prior to requesting approval from the BCSS. The case manager shall maintain the documentation in the recipient's records.

SERVICE LIMITS

A lifetime cap of $3000 per individual recipient is entered as a systems edit. Expenditures are cumulative, and claims which exceed this amount will be denied. The case manager shall carefully examine the recipient's record to determine whether the cap has been reached prior to requesting approval from the BCSS.

PERSONAL EMERGENCY RESPONSE SYSTEMS

A Personal Emergency Response System (PERS) provides immediate assistance in the event of a physical, emotional, or environmental emergency through a community-based electronic communications device. The unit is connected to the telephone line and is programmed to send an electronic message to a community-based 24 hour emergency response center once a "Help" button is activated. This unit may either be either worn by the recipient or installed in his/her home.

The PERS is only appropriate for individuals who are cognitively and/or physically able to operate the system and have periods when they are solely responsible for their own care.

The PERS must be checked monthly by the provider to insure it is properly functioning.

STANDARDS

These devices must meet Federal Communications Commission standards or Underwriter's Laboratory standards or equivalent standards.

SERVICE LIMITS

Billing for this service involves an installation fee and a monthly fee. Only one claim for each month will be allowed. Claims may be span dated (or not) at the discretion of the provider. Partial months shall not be billed.

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STAFFING REQUIREMENTS
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INTRODUCTION

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

CASE MANAGEMENT REQUIREMENTS

Each DHH Regional Case Management agency must have an on-site project manager, case manager supervisor and case managers.

Contractors of Case Management services cannot "reject" or deny services to any recipient that has been linked to their agency unless one of the following occurs:

- The case manager is providing service to the recipient.
- If an exception has been given by the Case Management Administrator for irreconcilable differences.

Each case management provider must ensure that each case manager and supervisor possess the minimum requisite skills, qualifications, training, supervision, and coverage in accordance with DHH requirements described in this section. In addition, the case management agency must maintain sufficient staff and office site(s) to adequately serve recipients in the DHH region(s) where they live within mandated caseload sizes described in this section of this manual. *All DHH Case Management requirements can be found in the DHH Case Management Services Manual.*

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

EDUCATION AND EXPERIENCE

The On-Site Project Manager are responsible for the overall operation of the agency and are responsible to the BCSS for Quality Assurance and Self-Evaluation. The education and

experience required of the On-Site Project Manager shall be identified by the agency.

NOTE: All employees must obtain a criminal history record check to be kept in their personnel files. These forms are obtained from Louisiana State Police.

Case Manager

All case managers must meet the following minimum qualifications for education and experience:

- A bachelor's degree in a human service-related field including but not limited to psychology, education, counseling, rehabilitation counseling or general studies with a major concentration in a human services-related field from an accredited institution;

  AND

  One (1) year of full-time paid post-degree experience in a human service-related field providing direct recipient services or case management/service coordination.

  Thirty (30) hours of graduate level course credit in the human service-related field may be substituted for the year of required paid experience.

  OR

- A licensed registered nurse;

  AND

  One (1) year of paid experience as a registered nurse in public health or a human service-related field providing direct recipient services or case management/service coordination.

  Thirty (30) hours of graduate level course credit in the human service-related field may be substituted for the year of required paid experience.

  OR

- A bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.

- Experience Qualifications

Experienced gained as part of the educational process, i.e., a field placement, internship or practicum, is part of the qualifying education and may not be counted toward the post-educational experience.

Experience gained while employed in a position in which ***minimum qualifications were not initially met*** cannot be counted toward the required experience.

Experience as a teacher does not qualify as direct services.

Case Management Supervisor or any Other Individual Supervising Case Managers

All case management supervisors must meet the qualifications for education and experience listed below.

- A master's degree in social work, psychology, nursing, counseling, rehabilitation counseling, education with special education certification, occupational therapy, speech therapy, physical therapy or general studies with a major concentration in a human services-related field from an accredited institution;

  AND

  Two (2) years of full-time paid post-master's degree experience in a human service-related field providing direct recipient services or case management/service coordination; one (1) year of this experience must be in providing direct services (teaching is not considered direct services) to people with developmental disabilities;

  OR

- A bachelor's degree in social work from a social work program accredited by the Council on Social Work Education;

  AND

  Three (3) years of full-time paid post-bachelor's degree experience in a human service-related field providing direct recipient services (teaching experience does not apply) or case management/service coordination; one (1) year of this experience must be in providing direct services to people with developmental disabilities;

  OR

- A licensed registered nurse;

AND

Three (3) years of full-time paid experience after licensure as a registered nurse in public health or a human service-related field providing direct recipient services or case management/service coordination; two (2) years of this experience must be in providing direct services to people with developmental disabilities;

OR

- A bachelor's degree in a human service-related field including but not limited to psychology, education, counseling, rehabilitation counseling or general studies with a major concentration in a human services-related field from an accredited institution;

  AND

  Four (4) years of full-time paid post-bachelor's degree experience in a human service-related field providing direct recipient services or case management/service coordination; two (2) years of this experience must be in providing direct services to people with developmental disabilities. Teaching is not considered direct services.

  Thirty (30) hours of graduate level course credit in the human service-related field may be substituted for one (1) year of required experience. All experience must be obtained after completion of the degree or licensure and must be professional level experience.

Note: **Experience gained as part of the educational process, i.e., a field placement, internship or practicum, is part of the qualifying education and may not be counted toward the post-educational experience.**

REQUISITE KNOWLEDGE, SKILLS AND ABILITIES

Each case management provider must look for the basic knowledge, skills, and abilities listed below which are essential to good case management practice in hiring case management staff. In addition, each case management agency must ensure that each staff member providing case management services possess this knowledge, skill, and ability prior to assuming full caseload responsibilities:

Knowledge

- Community resources
- Medical terminology
- Case management principles and practices

- Recipient rights
- State and federal laws for public assistance

Skills

- Time management
- Assessment/evaluation
- Interviewing
- Listening

Abilities

- Preparing care plans
- Coordinating delivery of supports and services
- Advocating for the recipient
- Communicating both orally and in writing
- Establishing and maintaining cooperative working relationships
- Maintaining accurate and concise records
- Assessing medical and social aspects of each case and formulating care plans accordingly
- Problem solving
- Remaining objective while accepting the recipient's/guardian's lifestyle

TRAINING FOR CASE MANAGEMENT STAFF

Case managers need ongoing training to maintain and improve their performance. Such training must be provided by or arranged by the case manager's employer at the *employer's expense*.

The required orientation and training for case managers and supervisors described in this section must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and the orientation/training agenda.

All training mandated by DHH is required in addition to the following:

Orientation and Training for New Employees

New Staff Orientation

- Orientation of at least sixteen (16) hours must be provided to all staff,

volunteers, and students within five (5) working days of employment.

- A minimum of eight (8) hours of the orientation training must cover orientation to working with people with developmental disabilities

  including, but not limited to, specific support and service needs and resources.

- This orientation must include, at a minimum:

  - Case management provider policies and procedures
  - Medicaid and other applicable DHH policies and procedures
  - Confidentiality
  - Documentation in case records
  - Recipient rights protection and reporting of violations
  - Recipient abuse and neglect reporting policies and procedures
  - Recognizing and defining abuse and neglect
  - Emergency and safety procedures
  - Data management and record keeping
  - Infection control and universal precautions
  - Working with people with developmental disabilities
  - Professional ethics
  - Personal Outcome measures

Training for New Staff

In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training during the first ninety (90) calendar days of employment.

- This training must be related to working with people who are elderly or adults who are disabled and have specific knowledge, skills, and techniques necessary to provide case management to these individuals.

- This training must be provided by an individual with demonstrated knowledge of both the training topics and the waiver population.

- This training must include, at a minimum, the following:

  - Assessment techniques

  - Support and service planning

- Resource identification
- Interviewing and interpersonal skills
- Data management and record keeping
- Communication skills
- Cultural awareness
- Personal outcome measures

- A new employee ***may not be given*** case management responsibility until the orientation is satisfactorily completed.

  Note: Routine supervision may not be considered training.

Annual Training

It is important for case managers to receive continuing training to maintain and improve skills. Each case manager must satisfactorily complete forty (40) hours of case-management related training annually which may include training updates on subjects covered in orientation and initial training.

- The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the forty (40) hour minimum annual training requirement.

- Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required forty (40) hours of annual training.

- The following is a list of suggested additional topics for training:

  - Nature of illness or disability, including symptoms and behavior
  - Pharmacology
  - Potential array of supports and services for people with developmental disabilities
  - Building informal and natural support systems
  - Family dynamics
  - Developmental life stages
  - Crisis support and management
  - First aid/CPR
  - Signs and symptoms of mental illness, alcohol and drug addiction, and head injuries
  - Recognition of illegal substances
  - Monitoring techniques

- Advocacy
- Positive behavioral support techniques
- Values clarification/goals and objectives
- Community resources
- Accessing special education services
- Cultural diversity
- Health management
- Team building/interagency collaboration
- Transition/closure
- Age and condition-appropriate preventive health care
- Use of teams/facilitation of teams
- Computers
- Stress and time management
- Legal issues
- Person-centered planning
- Self-determination or recipient-directed services
- Outcome measures

Training for Supervisors

Each case management supervisor must complete a minimum of forty (40) hours of training a year. In addition to the required and suggested topics for case managers, the following are suggested topics for supervisory training:

- Professional identification/ethics
- Process for interviewing, screening, and hiring of staff
- Orientation/in-service training of staff
- Evaluating staff
- Approaches to supervision
- Managing caseload size
- Conflict resolution
- Documentation
- Time management

Mandatory DHH Case Management Training

Case management agencies must ensure that case management staff attend and satisfactorily complete DHH case management training on case management policies and procedures. Certificates will be given for attendees and will indicate the hours and training category.

CASE MANAGEMENT STAFF COVERAGE

All staff and caseload information shall be continuously updated as it occurs and entered in the database issued by BCSS. This database remains the property of BCSS.

Hours

The case management agency must ensure that case management services are available twenty-four (24) hours a day, seven (7) days a week, through the agency's toll-free number.

- Each case manager must be employed forty(40) hours per week and work at least 50% of the time during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday).
- There must be one (1) full time case management supervisor for every eight (8) case managers.
  - A supervisor must maintain on-site office hours at least 50% of the time during normal business hours in order to comply with all of the supervision requirements as described in this section.
  - A supervisor must also be continuously available to case managers by telephone or beeper at all times when not on site.

Note: **Contracting with on-site project managers, case manager supervisors, and case managers is prohibited. Agencies that have a DHH Medicaid Contract may sub-contract with licensed agencies with prior approval by DHH.**

Supervision

Each case management agency must have and implement a written plan for supervision of all case management staff. Case managers must be evaluated at least annually by their supervisor according to written provider policy on evaluating their performance.

Methods of Supervision

- Supervision of individual staff must include the following:
  - Direct review, assessment, problem solving, and feedback regarding

the delivery of case management services;

- Teaching and monitoring of the application of person centered principles and practices;
- Assuring quality delivery of services;
- Managing assignment of caseloads;
- Arranging for training as appropriate; and
- Directing staff in meeting outcomes.

- Supervision must be accomplished by a combination of the following means:
  - Individual, face-to-face sessions with staff to review individual cases, assess performance and give feedback. Individual face-to-face supervision must occur at least one (1) time per week per case manager for a minimum of one (1) hour per week.
  - Face-to-face sessions with all case management staff to problem solve, provide feedback and support to case managers.
  - Sessions in which the supervisor accompanies a case manager to meet with the recipient. The supervisor assesses, teaches, and gives feedback regarding the case managers's performance related to the particular recipient.
  - Supervisors must review at least ten (10) percent of each case manager's case records each month for completeness, compliance with these standards, and quality of service delivery.

Sharing Onsite Project Managers

Agencies having more than one contract where project managers share administrative responsibilities must submit a plan to the BCSS Case Management Program Administrator. This plan must be approved prior to its implementation. The plan's approval is completely at the discretion of the BCSS Case Management Program Administrator and may be terminated at anytime it is determined that the administrative needs of any region are not being met. The plan must be signed by the contract administrator and include the following information:

- A work plan that outlines the duties of each project manager.

- Outline the projected number of days the managers will be in each office and how they will maintain contact.

Supervisory Record Keeping

Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum:

- Date, time, and content of the supervisory sessions; and
- Results of the supervisory case review which must address, at a minimum: completeness and adequacy of records; compliance with standards; and, effectiveness of services.

Caseload Size and Mix

- Case Management Supervisor

The case management supervisor must not supervise more than eight (8) full-time case managers or other professional-level human service staff.

  - A supervisor may carry 8% of a caseload for each case manager supervised when fewer than eight (8). But never more than 50% of their time can be used for caseloads.
  - A supervisor carrying a caseload must be supervised by an individual who meets the supervisory qualification as described in this section.
  - A plan must be approved by the BCSS Case Management Administrator prior to it being implemented.

- Case Manager Caseload Size and Mix

  - Each full-time case manager can have a caseload of no more than thirty-five (35) recipients.
  - The caseload mix and size should be monitored by the supervisor to

ensure that the case manager can adequately manage.

Part-time Case Managers

A part-time case manager may be used for specific period of time to cover a temporary increase in the number of recipients such as additional waiver slots. In no case can a part-time case manager be employed for more than three months. Part-time case mangers must meet all qualification for a case manager. All request must be approved by the BCSS Case Management Program Administrator. Request for approval will be monitored for frequency of request and must contain the following information:

- Name of the supervisor;
- An assurance that the agency supervisory personnel will respond in a timely manner during the 40 hour work week, and identify who will be responsible for emergencies that may arise after normal business hours;
- A signed statement by the part-time case manager that he/she has no other job;
- A monitoring plan to assure the person's availability and response time to the recipient; and
- Plans must be signed by the agency's contract administrator (name on the Board Resolution).

On-Site Project Managers

The responsibilities of the On-site Project Manager are to supervise the program, direct the staff, communicate with the Case Management Contract Administrator, implement and carry out Quality Improvement and like administrative duties. These employees shall not carry a caseload or be a supervisor of case managers. The exception will be when a *temporary plan* has been submitted for a *temporary* increase in an agencies caseload. All plans must be approved by the Case Management Contract Administrator prior to implementation.

DIRECT SERVICE PROVIDER REQUIREMENTS

Each direct service provider agency must ensure that each direct service staff person possesses minimum requisite skills, qualifications, training, supervision, and coverage in accordance with the DHH requirements in this section. In addition, each direct service

provider agency must maintain sufficient staff to adequately serve recipients.

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

Legally responsible relatives shall ***not*** be employed by the service provider to provide direct support services reimbursed through the EDA waiver. This would include:

- Spouses,
- Parents or stepparents,
- Foster parents, or
- Legal guardians

Family members who provide paid support services to the recipient must meet the same standards as personal care attendants who are unrelated to the recipient.

NOTE: ***All employees who work with EDA recipients must have a criminal history records check and it must be kept in their personnel file. These forms are obtained from Louisiana State Police.***

EDUCATION AND EXPERIENCE

Administration:

The responsibilities of the agency administrators/directors are to supervise the program, direct the staff, implement and carry out quality improvement and like administrative duties.

- Agency Directors/Administrators are responsible for the overall operation of the agency and are responsible to the BCSS for Quality Assurance and Self-Evaluation. The education and experience required of the Agency Director/Administrator shall be identified by the agency.
- Each agency must employ a minimum of one employee at the supervisory level or higher who has a bachelor's degree in a human service-related field. This employee may be part-time but must meet the following requirements:
    - Have consulting availability to the agency
    - Review records and plans for each recipient at a minimum of every

6 months

- Must have documented active participation in policy/procedure development and agency staff orientation and annual training
- Provide a minimum of 4 on-site hours per month of service to the agency.

The enrolled agency must demonstrate that the services delivered by this staff member are adequate to enhance the quality of services delivered by the agency to recipients of the EDA waiver.

Direct service staff:

Each direct service staff must have a high school diploma or equivalency.

REQUISITE KNOWLEDGE, SKILLS, AND ABILITIES

Each direct service provider must look for the basic knowledge, skills, and abilities listed below which are essential to service delivery in hiring direct service staff. In addition, each provider must ensure that each staff member providing direct services possess this knowledge, skill, and ability prior to working with recipients:

Knowledge

- Community resources
- Medical terminology
- Recipient rights

Skills

- Assessment/evaluation
- Interviewing
- Listening

Abilities

- Following care plans
- Documenting delivery of supports and services
- Advocating for the recipient
- Communicating both orally and in writing
- Establishing and maintaining cooperative working relationships
- Maintaining accurate and concise records
- Problem solving

- Remaining objective while accepting the recipient's/guardian's lifestyle

TRAINING FOR DIRECT SERVICE STAFF

Direct service staff need ongoing training to maintain and improve their performance. Such training must be provided by or arranged by the direct service staff's employer at the employer's expense.

The required orientation and training for direct service staff and supervisors described in this section must be documented in the employee's personnel record including: dates and hours of specific training, trainer or presenter's name, title, agency affiliation or qualification, other sources of training and the orientation/training agenda.

All training mandated by DHH is required in addition to the following:

Orientation and Training for New Employees

New Staff Orientation

- Orientation of at least sixteen (16) hours must be provided to all staff, volunteers, and students within five (5) working days of employment.
- This orientation must include, at a minimum:
  - Direct service provider policies and procedures
  - Medicaid and other applicable DSS/DHH policies and procedures
  - Confidentiality
  - Documentation in case records
  - Recipient rights, protection, and reporting of violations
  - Recipient abuse and neglect reporting policies and procedures
  - Recognizing and defining abuse and neglect
  - Emergency and safety procedures
  - Data management and record keeping
  - Infection control and universal precautions
  - Working with people who are elderly and disabled
  - Professional ethics
  - Personal Outcome measures

Training for New Staff

In addition to the required sixteen (16) hours of orientation, all new employees with no documented training must receive an additional minimum sixteen (16) hours of training

during the first ninety (90) calendar days of employment.

- This training must be related to working with elderly people and individuals with developmental disabilities and specific knowledge, skills, and techniques necessary to provide direct services to people with developmental disabilities.

- This training must be provided by an individual with demonstrated knowledge of both the training topics the waiver population.

- This training must include the following at a minimum:

  - Assessment techniques
  - Support and service delivery
  - Resource identification
  - Interviewing and interpersonal skills
  - Data management and record keeping
  - Communication skills
  - Cultural awareness
  - Personal outcome measures

- A new employee ***may not be given*** direct support work responsibility until the orientation is satisfactorily completed.

  Note: Routine supervision may not be considered training.

Annual Training

It is important for direct service staff to receive continuing training to maintain and improve skills. Each direct service staff must satisfactorily complete forty (40) hours of direct service related training annually which may include training updates on subjects covered in orientation and initial training.

- The sixteen (16) hours of training for new staff required in the first ninety (90) days of employment may be part of the forty (40) hour minimum annual training requirement.

- Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required forty (40) hours of annual training.

- The following is a list of suggested additional topics for training:

  - Nature of illness or disability, including symptoms and behavior

- Pharmacology
- Potential array of community supports and services for the elderly
- Building informal and natural support systems
- Family dynamics
- Developmental life stages
- Crisis support and management
- First aid/CPR
- Signs and symptoms of mental illness, alcohol and drug addiction, developmental disabilities and head injuries
- Advocacy
- Positive behavioral support techniques
- Values clarification/goals and objectives
- Community resources
- Positioning & physical management
- Cultural diversity
- Health care management including preventive health care
- Team building/membership/interagency collaboration
- Team membership in human service
- Stress and time management
- Legal issues
- Outcome measures
- Person-centered planning
- Self-determination or recipient-directed services
- Alzheimers/dementia

Training for Supervisors

Each direct service provider supervisor must also complete a minimum of forty (40) hours of training a year. In addition to the required and suggested topics for case managers, the following are suggested topics for supervisory training:

- Professional identification/ethics
- Process for interviewing, screening, and hiring of staff
- Orientation/in service training of staff
- Evaluating staff
- Approaches to supervision
- Managing workloads
- Conflict resolution
- Documentation
- Time management

Mandatory DHH Training

Direct service agencies must ensure that direct service staff attend and satisfactorily complete mandated DHH training. Certificates will be given for attendees and will indicate the hours and training category.

DIRECT SERVICE PROVIDER STAFF COVERAGE

Hours

The direct service provider agency must ensure that recipients can access the agency twenty-four (24) hours a day, seven (7) days a week, through a toll-free number.

A supervisor must also be continuously available to direct care staff by telephone or beeper at all times when not on site.

Supervision

The direct service provider must have and implement a written plan for supervision of all direct service staff. Direct service staff must be evaluated at least annually by their supervisor according to written provider policy on evaluating their performance.

Methods of Supervision

- Supervision of individual staff must include the following:
- Direct review, assessment, problem solving, and feedback regarding the delivery of services;
- Teaching and monitoring of the application of services;
- Assuring quality delivery of services;
- Managing work assignments;
- Arranging for training as appropriate; and
- Directing staff in meeting outcomes.
- Supervision must be accomplished by a combination of the following

means:

- Individual, face-to-face sessions with staff to review individual cases, assess performance and give feedback.
- Face-to-face sessions with all direct service staff to problem solve, provide feedback and support to staff.
- Sessions in which the supervisor accompanies a direct service staff to meet with the recipient. The supervisor assesses, teaches, and gives feedback regarding the direct service staff's performance related to the particular recipient;

Supervisory Record Keeping

Each supervisor must maintain a file on each direct service staff supervised and hold supervisory sessions on at least a weekly basis. The file on the direct service staff must include, at a minimum:

- Date, time, and content of the supervisory sessions; and
- Results of the supervisory case review which must address, at a minimum: completeness and adequacy of records; compliance with standards; and, effectiveness of services.

All case assignments should be monitored by the supervisor to ensure that the direct service staff can adequately manage their caseload.

SECTION 7
RECORD KEEPING/DOCUMENTATION

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GENERAL RECORD KEEPING

Failure to comply with record keeping requirements may result in one or more of the following: recoupment, sanctions, loss of enrollment, or referral to Surveillance and Utilization Review Systems (SURS).

COMPONENTS OF RECORD KEEPING

All provider records must be maintained in an accessible, standardized order and format at the DHH enrolled office site. The agency must have sufficient space, facilities, and supplies to ensure effective record keeping.

The provider must keep sufficient records to document compliance with DHH requirements for the recipient served and the provision of services.

Services billed must clearly be related to the current CPOC.
A separate record must be maintained on each recipient that fully documents services for which payments have been made. The provider must maintain sufficient documentation to enable DHH to verify that prior to payment, each charge is due and proper.

- The provider must make available all records that DHH finds necessary to determine compliance with any federal or state law, rule, or regulation promulgated by DHH

RETENTION OF RECORDS

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

- Until records are audited and all audit questions are answered

OR

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

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

CONFIDENTIALITY AND PROTECTION OF RECORDS

Records, including administrative and recipient, must be the property of the the provider, and he/she must secure the records against loss, tampering, destruction or unauthorized use.

- Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the recipients or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information which might identify the recipients or their families. The information may be released only under the following conditions:
  - By court order, or;
  - By the recipient's written, informed consent for release of information.
    - When the recipient has been declared legally incompetent, the individual to whom the recipient's rights have devolved provides written consent.
    - When the recipient is a minor, the parent or legal guardian provides written consent.
    - In compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).
  - Upon request, a provider must, upon request, make available information in the case records to the recipient or legally responsible recipient. If, in the professional judgement of the administration of the agency, it is felt that information contained in the record would be damaging to the recipient, that information may be withheld from the recipient except under court order.
    - The provider may charge a reasonable fee for providing the above records.
    - A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge or the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted.
- A system must be maintained that provides for the control and

location of all recipient records. Recipient records must be located at the enrolled site.

Note: Under no circumstances should providers allow staff to take recipient's case records from the facility.

REVIEW BY STATE AND FEDERAL AGENCIES

Providers must make all administrative, personnel, and recipient records available to DHH and appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of recipient information.

ADMINISTRATIVE FILES

The provider's administrative files must include at a minimum:

- Documents identifying the governing body,
- List of members and officers of the governing body, their addresses and terms of membership,
- Minutes of formal meetings and bylaws of the governing body, if applicable,
- Documentation of the provider's authority to operate under state law,
- Functional organizational chart which depicts lines of authority,
- All leases, contracts and purchase-of-service agreements to which the provider is a party,
- Insurance policies,
- Annual budgets, audit reports and accounting records,
- Master list of all service providers to whom the provider refers recipients,
- Provider's policies and procedures,
- Documentation of corrective action taken as a result of external or internal reviews,
- Plan for recruitment, screening orientation, ongoing training, development and supervision and performance evaluation of staff,
- Procedures for the maintenance, security, and confidentiality of records

that specify who supervises the maintenance of records and who has custody of records,

- Quality Improvement Plan,
- A clear, concise program description, which is made available to the public, detailing:
  - Overall philosophy of the services
  - Long and short term goals of the services
  - Target and/or waiver group(s) of recipients served
  - Intake and closure criteria
  - Written eligibility criteria for each service provided
  - Services to be provided
  - Schedules of fees for services, including a sliding scale, which will be charged to non-Medicaid recipients, if applicable
  - Method of obtaining opinion from the recipient regarding recipient satisfaction with services
- A current comprehensive resource directory of existing formal and informal services that addresses the unique needs of the elderly and disabled adultsd which must be updated at least annually.
- Accounting records maintained according to generally accepted accounting principles as well as state and federal regulations and accounting records maintained by the accrual method of accounting.

Note: ***Purchase discounts, allowance and refunds will be recorded as a reduction of the cost to which they relate.***

- All fiscal and other records concerning services as they are subject at all times to inspection and audit by the Department, the Legislative Auditor, and auditors of appropriate federal funding agencies.
- All required elements/documents as per licensing standards.

PERSONNEL FILES

The provider must have written employment and personnel policies that include:

- Job descriptions for all positions, including volunteers and students, that specify duties, qualifications, and competencies.
- Description of hiring practices that includes a policy against discrimination based on race, color, religion, sex, age, national origin, disability, political beliefs, disabled veteran, veteran status or any other non merit factor.
- Description of procedures for:
  - Employee evaluation
  - Promotion
  - Disciplinary action
  - Termination
  - Hearing of employee grievances
    - There must be written grievance procedures that allow employees to make complaints without fear of retaliation. Grievances must be periodically reviewed by the governing body in an effort to promote improvement in these areas.

A provider must have a written record on each employee that includes:

- Application for employment and/or resume'
- Three (3) references
- Valid driver's license for operating a vehicle and valid automobile insurance
- Verification of professional credentials required to hold the position including the following, if relevant: current licensure, education, training, and, experience
- Periodic, at least annual, performance evaluations
- An employee's starting and termination dates along with salary paid.
- Copies of criminal records check for all employee's.

An employee must have reasonable access to his/her personnel file and must follow the policies and procedures related to personnel. A provider must not release a personnel file without the employee's written permission except according to state law.

RECIPIENT RECORDS

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

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

Note: ***General terms such as "called the recipient" or "supported recipient" or "assisted recipient" is not sufficient and does not reflect adequate content. Check lists alone are not adequate documentation.***

The BCSS does not prescribe a format for documentation, but must find all components outlined below. The schedule for documentation differs based on each waiver/service system. See the Table for Documentation Schedule at the end of this section.

ORGANIZATION OF RECORDS, RECORD ENTRIES AND CORRECTIONS

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

All entries and forms completed by staff in recipient records must include:

- The name of the person making the entry
- A legible signature of the person making the entry
- A functional title of the person making the entry
- The full date of documentation
- Be legible
- In ink
- Reviewed by the supervisor, if required

Any error made by the staff in a recipient's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and

initial the correction. Correction fluid must never be used in a recipient's records.

COMPONENTS OF RECIPIENT RECORDS

The recipient's case record must consist of the active recipient record and the agency's storage files or folders.

Active Record

The active record must contain, *at a minimum*, the following information:

- Identifying information on the recipient recorded on a standardized form including the following:
  - Name
  - Home address
  - Home telephone number
  - Date of birth
  - Sex
  - Race or ethnic origin (optional)
  - Closest living relative/ legal guardian/ legally responsible relative
  - Education
  - Marital status
  - Date of initial contact
  - Court and/or legal status, including relevant legal documents
  - Names, addresses, and phone numbers of other recipients or providers involved with the recipient's CPOC including the recipient's primary or attending physician
  - Date this information was gathered
  - Signature of the staff member gathering the information.

- Documentation of the need for ongoing services.

- Medicaid eligibility information for Medicaid eligible recipients.

- A copy of an assurances of freedom of choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc. signed by the recipient.

- Complete service plan as specified in the *Services Section* of this manual signed and dated by the recipient.
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified below.

- Content and outcome of service contact

There must be case record entries corresponding to each recorded case management and direct service provider activity, and they must relate to one of the personal outcomes.

- The service log entries need not be a narrative with every detail of the circumstances; however, all case notes must be clear as to who was contacted and what activity took place.

- Services billed must clearly be related to the current CPOC.

- Logs must be reviewed by the supervisor to insure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient.

Each case management service contact is to be briefly defined (i.e., telephone call, face-to-face visit) with a narrative in the form of a progress note. This documentation should support justification of critical case management elements for Prior Authorization of service in the CMIS system.

Each direct service provider's documentation should support justification for Prior Authorization or payment of services.

Progress Notes (Summary)

Progress notes are the means of summarizing activities, observations and progress toward meeting service goals in the CPOC. Progress notes and summaries must:

- Indicate who was contacted, where contact occurred, and what activity occurred.

- Record activities and actions taken, by whom, and progress made; and indicate how the recipient is progressing toward the Personal Outcomes in the CPOC.

- Document delivery of each service identified on the CPOC.

- Record any changes in the recipient's medical condition, behavior or home situation which may indicate a need for a reassessment and CPOC change.

- Be legible (including signature) and include the functional title of the person making the entry and date.

- Be complete and updated in the record preferably weekly, but at least monthly and signed by the person providing the services, case managers or direct service agency staff.

- Be recorded more frequently (weekly) when there is frequent activity or significant changes occur in the recipient's service needs and progress.

Each case management provider shall document progress as a narrative that reflects each entry into the service log and elaborate on the substance of the contact. The progress notes shall summarize all activities for a specified period which addresses significant activities and progress/lack of progress toward the desired outcomes and changes in the social history.

Note: ***This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other case managers or their supervisors, and allows for evaluation of activities by program monitors.***

Each direct service provider shall document progress as a narrative that reflects each entry into the service log/payroll sheet and elaborate on the activity of the contact. The progress notes shall summarize all activities for a specified period which addresses significant activities and progress/lack of progress toward the desired outcomes and changes that may impact the CPOC and the needs of the individual.

Note: This summary should be sufficient in detail and analysis to allow for evaluation of the appropriateness of the current CPOC, allow for sufficient information for use by other direct support staff or their supervisors, and allow for evaluation of activities by program monitors.

A summary must also be entered in the recipient's record when a case is transferred or closed.

TABLE OF DOCUMENTATION SCHEDULE

CASE MANAGEMENT PROVIDERS

WAIVER	SERVICE LOG	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
Children's Choice	At time of activity	At time of activity	Between 6th and 9th month or more frequently if indicated.	Within 14 days of discharge
MR/DD	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge
Elderly and Disabled Adult	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge
Personal Care Attendant	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge
Adult Day Health Care	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge

SERVICE PROVIDERS

WAIVER	SERVICE LOG/ PAYROLLSHEET	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
Children's Choice	At time of activity	At time of activity	Between 6th and 9th month or more frequently if indicated.	Within 14 days of discharge
MR/DD	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge
Elderly and Disabled Adult	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge
Personal Care Attendant	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge
Adult Day Health Care	At time of activity	At time of activity	At least every 90 days	Within 14 days of discharge

SECTION 8
FINANCIAL REQUIREMENTS/REIMBURSEMENTS

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PRIOR AUTHORIZATION

CASE MANAGEMENT

The Elderly and Disabled Adult case management is provided by contract case management and non-contract case management which is billed to the fiscal intermediary using procedure code Z0195 as the specific billing code.

The procedures for issuing prior authorization (PA) numbers for Elderly and Disabled Adult case management recipients are as follows:

NEW CASE MANAGEMENT RECIPIENTS

- Freedom of Choice (FOC) Forms for case management are provided to the recipient only by the Councils on Aging (COA). BCSS or its agent receives FOC from the recipient or COA showing the selected choice.

- The BCSS or its agent links the recipient to his/her choice of agency, depending on availability.

- The BCSS or its agent notifies the linked agency of a new recipient by mailing the agency the FOC form with a workday report. In addition, the BCSS or its agent notifies the recipient of the assigned agency. Only linkages from the BCSS or its agent are valid.

- The BCSS or its agent shall receive the **Requested Waiver Services and Approval Page of the CPOC** from the case management agency by mail no more than 60 days from the CPOC date. This information will not be accepted by telephone or fax.

TRANSFER OF RECIPIENT

- FOC Forms for Case Management are provided to the recipient only by the COA point of entry.

- The COA will forward the new FOC to BCSS or its agent along with the Form 148 showing change and transfer.

- The BCSS or its agent will notify the linked agency of a new recipient by mailing the agency the FOC form indicating the transferring agency attached to the workday journal. Only linkages from the BCSS or its agent are valid.

- The receiving agency must contact the transferring agency to obtain the required records. Both the transferring and receiving agencies complete the Transfer of Records Form. The receiving agency is responsible for delivering services to the recipient beginning on the transfer of records date. The transferring agency is responsible for delivering services to the recipient through the transfer of records date. Therefore, to assure payment to the agency performing the task, the transfer should take place as close to the end of the month as possible. The receiving agency mails the completed Freedom of Choice/Transfer of Records Form to the BCSS or its agent. The Transfer of Records Form will not be accepted by phone or fax.

- A new Form 14 will be issued with an effective starting date of the first day of the first month after the date of transfer of records, but in no case will the BCSS or its agent "backdate" the PA prior to the first day of the month in which the Transfer of Records Form was received by the BCSS or its agent. The transferring agency's PA will expire on the date of transfer of records.

CASE CLOSURE

The case management agency will submit the FORM 148 to the BCSS and the local Medicaid office with the reason for closure noted.

REPLACEMENT PA REQUEST FORM

Date of Request: ___ / ___ /_____

Agency Name: _____

Agency Region: _____

Medicaid Provider Number: _____

Agency Telephone: _____

Agency Fax: _____

Recipient Name: _____
(Please Print)

Recipient SSN Number: _____ - ____ - _____

Existing PA Number: _____

New Medicaid Number: _____

_____ _____
Signature of Requesting Party Date

Please mail request to:

Statistical Resources, Inc.
Case Management
11505 Perkins Rd., Suite H
Baton Rouge, LA 70810

IT IS NOT THE RESPONSIBILITY OF THE BCSS OR ITS AGENT TO VERIFY MEDICAID ELIGIBILITY OR TO DETERMINE IF THE RECIPIENT IS IN THE TARGET POPULATION. THIS IS THE PROVIDER'S RESPONSIBILITY.

PRIOR AUTHORIZATION CHECKLIST

(Please Print Information)

Agency Name: _____

Agency Region: _____

Recipient Name: _____

Recipient SSN: _____

Recipient DOB: _____

Recipient Medicaid #: _____

Must have 13-digit Medicaid number, not the CCN Number

PROGRAM:

☐ Louisiana Children's Choice (New Recipient)
- ○ CPOC Approval Page

Louisiana Children's Choice (Transfer Recipient)
- ○ Freedom of Choice / Transfer of Records

☐ MR/DD Waiver (New Recipient)
- ○ CPOC Approval Page

MR/DD Waiver (Transfer Recipient)
- ○ Freedom of Choice / Transfer of Records

☐ Infant and Toddler
- ○ Freedom of Choice / Transfer of Records
- ○ CN 9 A & B
- ○ CN 1
- ○ IFSP Signature Page

☐ Elderly and Disabled Adult Waiver (New Recipient)
- ○ CPOC Approval Page

Elderly and Disabled Adult Waiver (Transfer Recipient)
- ○ Freedom of Choice / Transfer of Records

☐ EPSDT - Target Population (New Recipient)
- ○ CPOC Approval Page

EPSDT - Target Population (Transfer Recipient)
- ○ Freedom of Choice / Transfer of Records

☐ HIV
- ○ Freedom of Choice / Transfer of Records
- ○ Approval Page of POC (Plan of Care)

IMPORTANT THINGS TO REMEMBER

Recipient Mailing Address:

Keep address current in the CMIS software. The CMIS data is used when mailing information to the recipients.

Site Information:

Edit/Modify site information in the CMIS software whenever there is any change. This data is used for contacting agencies.

PA Request:

PA's should be received within 7 days of sending the request to the BCSS or its agent. If no response has been received from the BCSS or its agent after 7 days, contact to the BCSS should be made.

Checklist:

Use the checklist that will be attached to verify that all the forms necessary to obtain a PA number are enclosed. Packets will be returned if incomplete.

Medicaid Numbers:

Verify the 13-digit Medicaid number for the recipient. Packets will be returned if incomplete.

Data Submission:

Submit data at least weekly to the BCSS or its agent.

Freedom of Choice Forms:

Under no circumstance will a PA be issued prior to the freedom of choice date.

SECTION 9
PROGRAM MONITORING

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INTRODUCTION

Services offered through the Elderly and Disabled Adult (EDA) waiver are closely monitored to assure compliance with DHH policy as well as applicable state and federal regulations. The BCSS staff conduct on-site reviews of each provider agency contracted with DHH. These reviews are conducted to monitor the provider agency's compliance with DHH Provider Enrollment's participation requirements, continued capacity for service delivery, quality and appropriateness of service provision to the waiver group, and the presence of the Personal Outcomes defined and prioritized by the individuals served. Administrative records, personnel records, and a sample of recipient records are also reviewed as well as provider billing practices. In addition, provider agencies are monitored with respect to:

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

A sample of recipient records will also be reviewed to assure appropriate services are documented and delivered.

The BCSS Regional Office staff is available to answer questions regarding the monitoring of the EDA waiver. A provider's failure to follow DHH/Medicaid policies and practices could result in the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

ON-SITE REVIEWS

On-site reviews are scheduled with the provider agency and conducted by BCSS Quality Management staff on a regular basis to:

- Ensure compliance with program requirements,
- Review billing practices, and

- Ensure that services provided are appropriate to meet the needs of the recipients served.

The BCSS Quality Management staff will utilize the "DHH Waiver Services Monitoring Report Form" during the on-site review and following the review to summarize review findings. The on-site review includes the components listed below.

ADMINISTRATIVE REVIEW

The Administrative Review includes:

- A review of administrative records,
- A review of most recent DSS survey and current DSS license,
- Other agency documentation, and
- Provider agency staff interviews to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the BCSS monitoring questions or findings may result in sanctions according to Section 10 of this manual are liquidated damages and/or recoupment of payment.

PERSONNEL RECORD REVIEW

The Personnel Record Review includes:

- A review of personnel files,
- Payroll records,
- Time sheets,
- Current organizational chart, and
- Provider agency staff interviews to ensure that case managers, direct service providers, and all supervisors meet the following staff qualifications
    - Education,
    - Experience,
    - Skills,
    - Knowledge,
    - Employment status,

- Hours worked,
- Staff coverage,
- Supervisor-case manager ratio,
- Caseload/recipient assignments,
- Supervision documentation , and
- Other applicable requirements.

INTERVIEWS

As part of the on-site review, the BCSS Quality Management staff will interview:

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

This interview process is to assess the overall satisfaction of recipients regarding the provider agency's performance, and to determine the presence of the personal outcomes defined and prioritized by the recipient/guardian. The process of interviewing people and determining the quality of service delivery satisfaction and presence of personal outcomes will be in accordance with the recognized national standard model on outcome measures approved by the BCSS.

RECIPIENT RECORD REVIEW

Following the interviews, the BCSS Quality Management staff may review the case records of a representative sample of recipients served. The records will be reviewed to ensure that the activities of the provider agency are associated with the appropriate services of

intake, ongoing assessment, planning (development of the CPOC), transition/closure, and that these activities are effective in assisting the individual to attain or maintain the desired personal outcomes. The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the recipients served.

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

- Identified in the CPOC;
- Provided;
- Documented properly;
- Appropriate in terms of frequency and intensity; and,
- Relate back to personal outcomes on the CPOC.

The BCSS Quality Management staff will review the intake documentation of the EDA waiver recipient's eligibility and procedural safeguards, case management and professional assessments/ reassessment documentation, service plans, service logs, progress notes and other pertinent information in the recipient record. An abbreviated "DHH Waiver Services Monitoring Report Form" is completed on each record reviewed.

QUALITY IMPROVEMENT PLAN

The provider agency's approved continuous Quality Improvement Plan (QIP) is reviewed to ensure that the agency is providing quality services and is responsive to the needs of recipients, including the personal outcomes defined and prioritized by the recipients.

- The quality improvement plan, any internal corrective action plans and documentation of QIP meetings of the provider agency are reviewed.
- Recipient input into service planning and timeliness of response to recipient requests are reviewed in the sampling of recipient records.
- The case management or direct service provider agency's involvement of recipient input in the improvement in quality of service provision is also reviewed.

PROVIDER SELF-EVALUATION

The purpose of the self-evaluation is to assess the presence of personal outcomes, as defined and prioritized by the recipient/guardian, as well as the presence of required case record documentation in a representative sample of individuals served by each employee. The self-evaluation is to assist the agency to prepare for the on-site review by the BCSS Quality Management staff and representatives of DHH Research and Development Section. The self-evaluation must be based on the process for interviewing people and determining the

presence of personal outcomes in accordance with the recognized national standard model on outcome measures approved by BCSS.

COMPONENTS OF THE PROVIDER SELF-EVALUATION

The self-evaluation must include:

- Interviews by the case management agency or direct service provider agency with the recipients in the representative sample,
- Interviews by the case management agency and direct service provider agency with others who know the individual best (family, friends, service and support providers, professionals, other members of the individual's network of support), and
- A review of the case records of the individuals in the representative sample.

REQUIREMENTS OF SELF-EVALUATION

Findings of the self-evaluation completed by the case management and direct service provider agency must indicate the presence of internal corrective action steps and progress to eliminate the problem area(s). Case record documentation in this representative sample must adhere to the requirements indicated in *Record Keeping/Documentation*, *Covered Services*, and *Provider Requirements*. The self evaluation must also indicate progress toward personal outcomes.

REPORT OF SELF-EVALUATION FINDINGS

The agency must submit four (4) copies of a report of the self evaluation findings to the following address:

Department of Health and Hospitals
Bureau of Community Supports and Services
446 N. 12th Street
Baton Rouge, LA 70802

The initial self-evaluation must be completed six (6) months after approval of the initial plan and then once a year after the first report.

This report must include:

- A description of the personal outcomes defined and prioritized by each of the recipients in the representative sample;
- Assessment of the required case record documentation in the representative sample;
- Written request or plan to acquire any needed technical assistance, training and/or support; and
- A sample of recipients included in the case record review is also surveyed to determine their satisfaction with the case management agencies and direct service providers. This part of the monitoring of the agency is to determine if the case management or direct service provider is generally meeting the needs of its recipients.

If the findings of the case management or direct service provider agency self-evaluation indicate that the agency is not working toward personal outcome requirements and/or case record documentation requirements, the self-evaluation report must also include a Quality Improvement Plan describing:

- How the agency will address issues with individual case managers or direct service staff to make systematic efforts to meet the personal outcome and case record documentation requirements.

MONITORING REPORT

Upon completion of the on-site review, the BCSS Quality Management staff discusses the preliminary findings of the review in an exit interview with appropriate staff of the case management or direct service provider agency. The BCSS Quality Management staff compiles and analyzes all data collected in the review, and a written report summarizing the monitoring findings and recommended corrective action is sent to the provider agency within **15 working days of the on-site visit.**

The monitoring report includes:

- Identifying information,
- Specific strengths and deficiencies identified in the review, including the presence of personal outcomes in the representative sample of recipients interviewed by the BCSS Quality Management staff,

- Recommended corrective action, and
- Deficiencies requiring corrective action by the case management or direct service provider agency listed in order of severity in the report.

Although the monitoring report has an educational component, any inappropriate reimbursement for possible recoupment action is identified in the report.

The BCSS Quality Management staff will review the reports and assess any sanctions as appropriate.

CORRECTIVE ACTION REPORT

The case management or direct service provider agency is required to submit a Plan of Correction (POC) to BCSS within 30 **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 agency is afforded an opportunity to discuss or challenge the BCSS monitoring findings.

Upon receipt of the written Plan of Correction (POC), the BCSS Quality Management staff reviews the agency's plan within **90 days** to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the BCSS Quality Management staff responds to the provider requesting immediate resolution of those deficiencies in question.

A follow-up monitoring visit may be conducted when serious deficiencies have been found to ensure that the provider has fully implemented the plan of correction.

After the case management or direct service provider agency has had the opportunity to address the review findings, the BCSS Quality Management staff sends a memorandum to the Surveillance and Utilization Review System (SURS) Unit recommending a recoupment amount.

MEDIATION (OPTIONAL)

In the course of monitoring duties, an informal hearing process may be requested. The agency 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 agency and in no way limits the right of the agency to a formal appeal hearing. In order to request the informal hearing, the agency should contact the Quality Management Administrator at

BCSS Quality Management Section
ATTN.: Informal Discussion
446 N. 12th Street
Baton Rouge, LA 70802
(225) 219 - 0203

Every effort will be made to schedule a hearing at the convenience of the agency.

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

The agency is notified of time and place where the informal hearing will be held. The agency should bring all supporting documentation that is to be submitted for consideration.

The BCSS Quality Management Administrator solicits representation from other sections within the BCSS and BCSS licensing as well as other persons within BHSF to participate in the informal hearing process. The Quality Management Administrator will select additional representatives to participate.

At the informal hearing, the Quality Management Administrator, who convenes the hearing,will keep the atmosphere informal. The agency is given the opportunity to present its case, to explain its disagreement with the monitoring findings, and/or to present new information. After the agency has explained its position, the agency representatives are are advised of the date that a written response will be sent. The agency is reminded of its right to a formal appeal.

The Quality Management Administrator engages the group in a discussion of the merits of the hearing. The Administrator moves for group consensus, and directs a member to record the panel's recommendations/decision that will be included in the written response.

This written response is sent to the agency and may contain directions with time-lines for completion.

There is no appeal of the informal hearing decision; however, the agency may appeal the original findings to the DHH Bureau of Appeals. Should the agency not fulfill the panel's recommendations, the agency's licensing authority will be notified of a recommendation to not renew the agency's license.

FRAUD AND ABUSE

When BCSS Quality Management staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section of the Medicaid Program for investigation and sanctions, if necessary. The Surveillance and Utilization Review System (SURS) of the Medicaid Program for investigation and sanctions, with information regarding fraud, abuse and SURS is found in Section 10 of this manual. DHH has an agreement with the Attorney General's Office which provides for the Attorney General's office to investigate Medicaid fraud. The Office of the Inspector General, Federal Bureau of Investigation (FBI), and Postal Inspectors also conduct investigations of Medicaid fraud.

SECTION 10
SANCTIONS

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GENERAL MEDICAID

To maintain the programmatic and fiscal integrity of the Louisiana Medicaid Program, the federal government and state government have enacted laws, promulgated rules and regulations and the Department has established policies concerning fraud, abuse and other invalid practices. It is the obligation of the provider to become familiar with these laws, rules, regulations and policies. This section of the manual is intended to assist the provider in becoming familiar with the laws, rules, regulations and policies concerning fraud, abuse and other incorrect practices committed against the Louisiana Medicaid Program. This section is not all inclusive nor does it constitute legal authority. This section is merely intended to inform the provider of the existence of laws, rules, regulations and policies concerning fraud, abuse and other incorrect practices.

GENERAL INFORMATION

Providers, recipients and others may be subject to criminal prosecution, civil action and/or administrative action if they violate laws, rules, regulations or policies applicable to the Medicaid Program. Federal laws and regulations and state laws require that the Louisiana Medicaid Program establish criteria that are consistent with principles recognized as affording due process of law for identifying situations where there may be fraud, abuse or other incorrect practices, for arranging prompt referral to the proper authorities, and for developing methods of investigation or review designed to ascertain the facts without infringing on the legal rights of the individuals involved. Both federal laws and regulations and state laws and regulations authorize the Department to conduct reviews of claims before and after they are paid in order to maintain the programmatic and fiscal integrity of the Louisiana Medicaid Program.

In general, suspected criminal activities are investigated and prosecuted by the Medicaid Fraud Control Unit of the Attorney General's Office, civil action are investigated and brought by the Department and/or the Attorney General's Office, and administrative actions are investigated and brought by the Department. Depending on whether the action is criminal, civil or administrative different standards of proof and levels of due process apply.

CRIMINAL FRAUD

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. In criminal proceedings, the definition of fraud that governs between citizens and state government agencies is found in *Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01, and Louisiana R.S. 14:70.5.*

- Legal action may be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142.

- Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts.

- All legal action is subject to due process of law and to the protection of the rights of the individual under the law.

PROVIDER CRIMINAL FRAUD

Examples of situations in which cases should be referred to the proper authorities for investigation include but are not limited to:

- Billing for services, supplies, or equipment that are not rendered to, or used for, Medicaid patients;

- Billing for supplies or equipment that are unsuitable for the patient's needs or are so lacking in quality or sufficiency as to be virtually worthless;

- Claiming costs for non-covered or non-chargeable services, non- allowable supplies, or equipment disguised as covered items;

- Materially misrepresenting dates and descriptions of services rendered, the identity of the provider, or of the recipient;

- Duplicate billing of the Medicaid Program or of the recipient, which appears to be a deliberate attempt to obtain additional reimbursement; and

- Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid.

RECIPIENT CRIMINAL FRAUD

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

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

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

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

Federal law also defines what is criminal conduct within federally funded programs. All persons should refer to the applicable federal laws and regulations.

The above lists are not all inclusive but rather illustrative of practices which may be considered criminal activities.

ABUSE AND OTHER INCORRECT PRACTICES

Abuse and other incorrect practices by providers, recipients and others include practices that are not criminal acts and may even be technically legal, but still represent the inappropriate use of public funds.

PROVIDER ABUSE AND OTHER INCORRECT PRACTICES

Cases involving one or more of the situations listed below may constitute sufficient grounds for investigation of a provider for incorrect practices or abuse.

- The provision of services that are not medically necessary;
- Flagrant and persistent overuse of medical or paramedical services with little or no regard for the patient's medical condition or needs, or for the doctor's orders;
- The unintentional misrepresentation of dates and descriptions of services rendered, of the identity of the recipient of the services, or of the individual who rendered the services in order to gain a larger reimbursement than is entitled; and
- The solicitation or subsidization of anyone by paying or presenting any person money or anything of value for the purpose of securing patients. Providers, however, may use lawful advertising that abides by the Bureau's rules and regulations.

This list is not all inclusive but rather illustrative of practices which are abusive or improper.

RECIPIENT ABUSE

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

- Unnecessary or excessive use of the prescription medication benefits of the Louisiana Medicaid Program;
- Unnecessary or excessive use of the physician benefits of the program; and
- Unnecessary or excessive use of other medical services and/or medical supplies that are benefits of the program.

Federal law also provides for civil remedies. All persons should refer to the applicable federal laws and regulations.

This list is not all inclusive but rather illustrative of practices which are abusive or improper.

CIVIL CAUSES OF AC10-6TION

The Medical Assistance Program Integrity Law (MAPIL) (see Section 3) which is contained in Louisiana Revised Statutes 46:437.1-46:440.3 provides for civil causes of action which can be taken against providers and others who violate the provisions of MAPIL. MAPIL prohibits illegal remuneration, false claims, illegal acts regarding eligibility and recipient lists among other things. These civil causes of action are set out in Louisiana Revised Statutes 46:438.1-46:438.5. Under MAPIL, individuals who are found by a court of law to have violated the provision of MAPIL are subject to triple damages, fines, cost and fees which can be enforced against the provider and others under the provisions of MAPIL.

ADMINISTRATIVE ACTIONS

Federal laws and regulations and state laws provide the Department with the responsibility and authority to bring administrative actions against providers, recipients and others who engage in fraudulent, abusive and/or other incorrect practices against the Bureau. Sanctions which may be imposed through the administrative process include but are not limited to denial or revocation of enrollment, revocation of licenses and/or certificates, withholding of payments, exclusion from the program, recovery of overpayments and imposition of administrative fines.

ADMINISTRATIVE SANCTIONS

To ensure the quality, quantity, and need for services, Medicaid payments may be reviewed, either prior to or after payment is made by the Bureau. Administrative sanctions may be imposed against any Medicaid provider who does not comply with laws, rules, regulations or policies.

DEFINITION OF ADMINISTRATIVE SANCTIONS

Administrative sanctions refer to any administrative actions taken by the Department against a medical service provider of Title XIX services that is labeled as a sanction. An administrative action is designed to remedy inefficient and/or illegal practices that are not in compliance with the Bureau's policies and procedures, statutes, and regulations.

GROUNDS FOR SANCTIONING PROVIDERS

The Bureau may impose sanctions against any provider of medical goods, services, or supplies if any of the following conditions apply/occur.

- A provider is not complying with the Bureau's policies, rules, and regulations, or the provider agreement that establishes the terms and conditions applicable to each provider's participation in the program.
- A provider has submitted a false or fraudulent application for provider status.
- A provider is not properly licensed or qualified, or a provider's professional license, certificate, or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated.
- A provider has engaged in a course of conduct; has performed an act for which official sanction has been applied by the licensing authority, professional peer population, or peer review board or organization; or has continued the poor conduct after having received notification by a licensing or reviewing authority indicating that the conduct should cease.
- A provider has failed to correct deficiencies in the delivery of services or billing practices after having received written notice of these deficiencies from the Bureau.
- A provider has been excluded from participation in Medicare because of fraudulent of abusive practices pursuant to Public Law 95-142, or has been convicted of Medicaid fraud (Louisiana R.S. 14:70.1).
- A provider has been convicted of a criminal offense relating to performance of a provider agreement with the state, to fraudulent billing practices, or to

negligent practice resulting in death or injury to the provider's patient.

- A provider has presented false or fraudulent claims for services or merchandise for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

- A provider has engaged in a practice of charging and accepting payment (in whole or in part) from recipients for services for which a payment has already been made by Medicaid.

- A provider has rebated or accepted a fee or a portion of a fee for a patient referral.

- A provider has failed to repay or arrange to repay an identified overpayment or otherwise erroneous payment.

- A provider has failed, after having received a written request from the Bureau, to keep or to make available for inspection, audit, or copies of records regarding payments claimed for providing services.

- A provider has failed to furnish any information requested by the Bureau or the fiscal intermediary regarding payments for providing goods and services.

- A provider has made, or caused to be made, a false statement or a misrepresentation of a material fact concerning the administration of the Louisiana Medicaid Program.

- A provider has furnished goods or services to a recipient that are in excess of the recipient's needs, not medically necessary, harmful to the recipient, or of grossly inadequate or inferior quality. (This determination would be based upon competent medical judgement and evaluation.)

- The provider, or a person with management responsibility for a provider, an officer or person owning (either directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporation, an owner of a sole proprietorship, or a partner in a partnership that is found to fall into one or more of the following categories:

- Was previously barred from participation in the Louisiana Medicaid Program;

- Was a person with management responsibility for a previously terminated provider during the time of conduct that was the basis for that provider's termination from participation in the Louisiana Medicaid Program;

- Was an officer, owner or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership or owner of a sole proprietorship or a partner of a partnership that was provider during the time of conduct that was the basis for that provider's termination from participation in the Louisiana Medicaid Program;

- Was engaged in practices prohibited by federal or state law or regulation;

- Was a person with management responsibility for a provider at the time that the provider engaged in practices prohibited by state or federal law or regulation;

- Was convicted of Medicaid fraud under federal or state law or regulation;

- Was a person with management responsibility for a provider at the time that the provider was convicted of Medicaid fraud under federal or state law or regulation; or

- Was an officer or owner or person owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership; or sole proprietorship or a partnership that was a provider at the time the a provider was convicted of Medicaid fraud under federal or state law or regulation; or

- Was an owner or a sole proprietorship or partner or a partnership that was a provider at the time such a provider was convicted of Medicaid fraud under federal or state law or regulation;

Federal laws and regulations also provide for administrative actions. All persons should refer to applicable federal laws and regulations.

This list is not all inclusive. The provider should refer to the regulations related to sanctioning.

LEVELS OF ADMINISTRATIVE ACTIONS AND SANCTIONS

Listed below are examples of the different levels of administrative sanctions that the Bureau may impose against a Medicaid provider:

Corrective Actions:

- Issuing a warning to a provider through written notice or consultation;
- Requiring that the provider receive education in policies and billing procedures;
- Requiring that the provider receive prior authorization for services;
- Placing the provider's claims on manual review status before payment is made;
- Refer the provider to professional or quasi-professional boards or peer review organizations.
- Refer the provider to outside law enforcement agencies.

Sanctions:

- Issue a warning;
- Require that provider terminate business association with an individual or entity;
- Limit the services which may be provided or the individuals to whom the services are provided;
- Recoupment;
- Recovery;
- Impose judicial interest on outstanding recoveries or recoupments;

- Impose reasonable costs;
- Exclude an individual or entity from participation;
- Suspend an individual or entity from participation;
- Impose a bond;
- Require forfeiture of a posted bond;
- Impose an arrangement to repay;
- Impose monetary penalties not to exceed $10,000;
- Impose withholding of payments.
- Withholding of payments and recovering money from the provider by deducting from future payments or by requiring direct payment for money improperly or erroneously paid;
- Referring a provider to the appropriate state licensing authority for investigation;
- Referring a provider for review by the appropriate professional organizations;
- Suspending a provider from participating in Louisiana Medicaid Program;
- Excluding a provider from participating in the Louisiana Medicaid Program;
- Imposing fines and costs;
- Imposing of bonds or other forms of security.
- Placing on prepayment review. (Prepayment review may be limited to those types of procedures for which misuse has been detected , or it may include a complete review of all the provider's claims).

Payments may be suspended to any provider who fails to meet the requirements for participation in the Louisiana Medicaid Program or for any other authorized reason.

This list is not all inclusive. The provider should refer to the laws and regulations related to sanctions for each program they are enrolled in and should review *Louisiana Register,* Vol. 25, No. 9, September 20, 1999, pages 1630-1650.

APPEALS

The Louisiana Department of Health and Hospitals (DHH) provides a hearing to any provider who feels that he has been unfairly sanctioned. Specifically, the Bureau of Appeals in the Department of Health and Hospitals is responsible for conducting hearings for providers who have complaints. Requests for hearings should explain the reason for the request and should be made in writing. The request should be sent directly to the Bureau of Appeals.

Detailed information regarding the appeals procedure may be obtained form the Bureau of Appeals at the following address:

DHH Bureau of Appeals
Post Office Box 4183
Baton Rouge, LA. 70821-4182

SECTION 11
CLAIMS FILING

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CLAIMS SUBMISSION AND PROCESSING

This section goes step-by-step through the process of billing for services provided under Louisiana Children's Choice. The HCFA 1500 universal claim form (revised 12/90) is to be used. Supplies of this form can be obtained from

Superintendent of Documents
Post Office Box 371954
Pittsburgh, PA 15250-7954
(202) 512-1800

or national claims forms vendors. A sample, along with detailed instructions for completing the HCFA 1500 is included in this section.

Providers are encouraged to file claims electronically via the Electronic Media Claim (EMC) process. Claims must be sent for processing on diskette (3 ½", 5¼", or 8"), on tape (reel-to-reel), or by telecommunications (modem). EMC runs on any IBM-compatible PC. In addition, a list of billing and management companies that provide electronic billing services is available from the fiscal intermediary Unisys.

Claims with attachments cannot be billed via EMC.

For more information or to request EMC specifications, the EMC Coordinator at Unisys may be contacted at (225) 237-3303.

PROCEDURE CODES AND SERVICE RATES

When billing for services provided under the Elderly and Disabled Adult Waiver, the following procedure codes and rates are applicable:

ELDERLY and DISABLED ADULT WAIVER		
Service	Procedure Code	Service Rate
Case Management	Z0195	$99.00 per month
Personal Care	Z0070	$5.00 per half hour unit
Household Supports	Z0071	$4.00 per half hour unit
Personal Supervision Day	Z0072	$3.00 per half hour unit
Personal Supervision Night	Z0073	$2.00 per half hour unit
Personal Emergency Response System Installation (P.E.R.S.)	Z0058	$30.00 Installation (Limit 1 installation)
Personal Emergency Response System Monthly (P.E.R.S)	Z0059	$27.00 Monthly Fee (Limit 12 units)
Environmental Modifications		Lifetime limit- combination limit $3,000.00
Ramp	Z0060	Each
Lift	Z0061	Each
Bathroom Modification	Z0062	Each
Adaptation	Z0063	Each

** *Rates as of July 1, 2001*

THIRD-PARTY LIABILITY (TPL)

Medicaid, by law, is intended to be ***the payor of last resort***. Therefore, other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid recipient.

If probable third party liability is established at the time the claim is filed, Medicaid will deny the claim and return it to the provider for determination of third party liability for most Medicaid services. In these cases the Bureau will then pay the balance of the claim to the extent that payment is allowed under Medicaid's fee schedule after the third party's payment.

EPSDT diagnostic and screening services are exempt from this requirement. For these services, Medicaid will pay the claim up to the maximum allowable amount. **However, these exceptions do not include treatment or therapy** which must be billed to the recipient's third-party carrier (if applicable) prior to billing Medicaid. When Medicaid is billed, the third-party carrier's Explanation of Benefits must be attached to the claim form.

CLAIM DOCUMENTATION

The Louisiana Medicaid Program is often required to make payment decisions based on information in medical records. These records must be properly documented to prevent payment errors. Proper documentation should include:

- Diagnosis and chief complaint
- Relevant history
- Examination findings
- Response to therapy
- Progress notes and patient disposition
- Procedures performed and test results
- X-ray, lab, diagnostic tests ordered with results
- Provision of services
- Actual cost of pass-through

TIMELY FILING GUIDELINES

To be reimbursed for services rendered, all providers must comply with the following filing limits set by the Medicaid Program.

- Straight Medicaid claims must be filed within 12 months of the date of service.

- Claims for recipients who have Medicare and Medicaid coverage must be filed with the Medicare Fiscal Intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulation.

- Most dual eligible claims will crossover to Medicaid via tape and do not need to be filed with the fiscal intermediary.

- Claims which fail to cross over via tape and have to be filed hard copy must be filed within six months of the date on the Medicare Explanation of Benefits (EOMB), provided that they were filed with Medicare within one year from the date of service.

- Claims with third-party liability (TPL) payment must be filed within 12 months of the date of service. After receipt of payment from the TPL, the Medicaid claim must be filed **hardcopy with an Explanation of Benefits (EOB) attached.**

- Claims for recipients with retroactive coverage, e.g., spend-down medically needy claims, should be sent to Unisys with a note of explanation AND a copy of Form 18-SSI (Medicaid Program Notice of Decision) or other official documentation from DHH indicating the recipient's retroactive status as soon as possible. The Unisys mailing address is as follows:

Unisys
Provider Relations
P. O. Box 91024
Baton Rouge, LA 70821

All claims for recipients with retroactive medical coverage will be forwarded to the Medicaid Program for review and authorization.

KIDMED claims must be filed within sixty (60) days of the date of service.

Medicaid claims received after the one (1) year maximum timely filing date cannot be processed unless the provider is able to furnish documentation of timely filing. This documentation must be legible and reference the individual recipient and date of service. It may include:

- A remittance advice (RA) indicating that the claim was processed within the original appropriate time frame; or
- Correspondence from either the state or parish Bureau of Health Services Financing office concerning the claim and/or the eligibility of the recipient.

Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include one of the following:

- A Remittance Advice indicating that the claim was processed earlier (within the specified time frame).
- Correspondence from either the Medicaid Program or local Medicaid eligibility staff concerning the claim and/or the eligibility of the recipient.
- To ensure accurate processing when resubmitting the claim and documentation, providers must be certain that the claim is legible. Documentation must reference the individual recipient and date of service.

TIPS ON TIMELY FILING FOR PROVIDERS

Providers must know how to bill correctly and how to resolve billing problems.

Because of timely filing limitations, providers must make the necessary claim corrections within the timely filing limits. Re-filing a claim several times without correcting previously cited errors IS NOT considered a valid attempt to resolve a billing problem.

All required items on the claim must be completed correctly.

Providers are notified of claims that are denied for payment by the Remittance Advice (RA.) A three (3) digit error code designating the error is printed for each claim. These codes are listed with a brief explanation being given for each one on a separate page of the RA following the status listing of all claims.

Providers must make their own corrections. It is against regulations for the fiscal intermediary to make claim corrections for a provider.

The fiscal intermediary offers consultation for providers having problems billing correctly and/or resolving billing problems. Contact Provider Relations at 1-800-473-2783 or (504) 924-5040.

CLAIMS FOR DATES OF SERVICE OVER TWO YEARS OLD

Claims with dates of service over two years old are not to be submitted to the fiscal intermediary or to the Medicaid Program for overriding of the timely filing edit unless one or more of the guidelines listed below is met.

- The recipient was certified for retroactive Medicaid benefits and the provider has filed a claim within 12 months of the date retroactive eligibility was granted.
- The recipient won a Medicare or SSI appeal in which he/she was granted retroactive Medicaid benefits.
- The failure of the claim to pay was the fault of the Medicaid Program rather than the provider's fault each time the claim was adjudicated.
- **Documentation of retroactive eligibility or the provider's attempts to resolve the billing problem must be attached to claim.**

HCFA 1500 BILLING INSTRUCTIONS

If items marked with an asterisk "*" are not completed, the claim will be denied.

Enter an "X" in the box marked Medicaid (Medicaid #)

*1. **Insured's ID Number**—enter the recipient's 13 digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card or through REVS or MEVS.

Make certain the recipient's name and number match. If the number does not match the recipient's name in block 2, the claim will be denied. If this item is blank, the claim will be returned.

*2. **Patient's Name**—Print the name of the recipient: last name, first name, middle initial. Spell the name exactly as it appears on the recipient's current Medicaid card.

3. **Patient's Birth Date and Sex**—Enter the recipient's date of birth as reflected in the current Medicaid information available through MEVS or REVS, using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero. Enter an "X" in the appropriate box to show the sex of the recipient.

4. **Insured's Name**—Complete correctly if appropriate or leave this space blank.

5. **Patient's Address**—Print the recipient's permanent address.

6. **Patient Relationship to Insured**—Complete if appropriate or leave this space blank.

7. **Insured's Address**—Complete if appropriate or leave this space blank.

8. **Patient Status**—Leave this space blank.

9. **Other Insured's Name**—Complete if appropriate or leave this space blank.

9A. **Other Insured's Policy or Group Number**—Complete with the 6-digit TPL carrier code if appropriate or leave this space blank.

9B. **Other Insured's Date of Birth**—Complete if appropriate or leave this space blank.

9C. **Employer's Name or School Name**—Complete if appropriate or leave this space blank.

9D. **Insurance Plan Name or Program Name**—Complete if appropriate or leave this space blank.

10. **Was Condition Related To**—Leave this space blank.

11. **Insured Policy Group or FECA Number**—Complete if appropriate or leave this space blank.

11A. **Insured's Date of Birth**—Complete if appropriate or leave this space blank.

11B. **Employer's Name or School Name**—Complete if appropriate or leave this space blank.

11C. **Insurance Plan Name or Program Name**—Complete if appropriate or leave this space blank.

12. **Patient's or Authorized Person's Signature**—Complete if appropriate or leave this space blank.

13. **Insured's or Authorized Person's Signature**—Obtain signature if appropriate or leave this space blank.

14. **Date of Current Illness**—Leave this space blank.

15. **Date of Same or Similar Illness**—Leave this space blank.

16. **Dates Patient Unable to Work**—Leave this space blank.

17. **Name of Referring Physician or Other Source**—Leave this space blank.

17A. **ID Number of Referring Physician**—Enter the referring physician's Medicaid ID number or, if a CommunityCARE recipient, the PCP's referral authorization number.

18. **Hospitalization Dates Related to Current Services**—Leave this space blank.

19. **Reserved for Local Use**—Leave this space blank.

20. **Outside Lab**—Leave this space blank.

*21. **Diagnosis or Nature of Illness or Injury**—Enter the numeric code and literal description. Use of ICD-9-CM coding is mandatory. Accepted abbreviations are appropriate.

22. **Medical Resubmission Code**—Leave this space blank.

*23. **Prior Authorization**—Complete if appropriate or leave space blank.

*24A. **Date of Service**—Enter the date the service for each procedure billed using six (6) digits (MM DD YY). If "from" and "to" dates are shown here for a series of identical procedures on the same day or on consecutive days, enter the number of services in item 24G. The date of dissemination may be used for evaluation services.

*24B. **Place of Service**—Enter the appropriate code.

24C. **Type of Service**—Leave this space blank.

*24D. **Procedure Code**—Enter the procedures using the applicable state assigned codes found in Section 11 of this manual.

*24E. **Diagnosis Code**—Reference the diagnosis entered in item 21 and indicate the most appropriate diagnosis for each procedure by entering either a "1, 2, 3, or 4." More than one diagnosis may be related to a procedure. Do not enter an ICD-9-CM diagnosis code in this item.

*24F. **Charges**—Enter your usual and customary charges for this procedure.

*24G. **Days or Units**—Enter the number of the same procedure being billed for the same date of service.

*24H. **EPSDT**—Enter a "Y".

24I. **EMG**—Leave this space blank.

24J. **COB**—Leave this space blank.

24K. **Reserved for Local Use**—Enter the attending provider number if applicable.

25. **Federal Tax ID Number**—Leave this space blank.

26. **Your Patient's Account Number**—(Optional) Enter the recipient's medical record number or other individual provider assigned number to identify the patient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of sixteen (16) characters.

27. **Accepts Assignment**—Leave this space blank. Medicaid does not make payments to the recipient. Claim filing shows acceptance of Medicaid assignment.

*28. **Total Charge**—Total of all charges listed on the claim.

29. **Amount Paid**—Complete if appropriate. Leave this space blank for EPSDT.

30. **Balance Due**—Complete if appropriate. Leave this space blank for EPSDT.

*31. **Signature of Physician/Supplier**—The claim form **MUST** be signed. The therapist is not required to sign the claim form. However, the therapist's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the physician, therapist or authorized representative. ***If this item is left blank, or if the***

stamped or computer-generated signature does not have original initials, the claim can not be processed for payment.

Date—Enter the date of the signature.

32. **Name and Address Where Services Were Rendered**—Leave this space blank.

*33. **Physician's or Medical Assistance Supplier's Name, Address, Zip Code and Telephone Number and PIN**—Enter the provider name, address including zip code and seven (7) digit Medicaid provider identification number. The Medicaid provider number must be entered in the space next to "PIN #." *If no Medicaid provider number is entered, the claim will be returned to the provider for correction and resubmission.*

PAID CLAIM ADJUSTING/VOIDING

The **Health Insurance Claim Adjustment/Void Form 213** is used to adjust or void a claim. ***Only a paid claim can be adjusted or voided***. When adjusting a paid claim, never change the Provider Identification Number or the Recipient/Patient Identification Number. The Adjustment/Void form allows the adjustment or voiding of only one line on one Adjustment/Void form. To adjust or void more than one claim line on a multiple line claim form, a separate Adjustment/Void form is required for each claim line.

GENERAL GUIDELINES

- Complete the information on the adjustment form exactly as it appears on the original claim, changing only that item or items that were in error and giving the reasons for the changes in the space provided.

- To void a paid claim, enter all of the information from the original claim **exactly** as it appears on the original claim. After a voided claim has appeared on the Remittance Advice (RA), an original claim can be resubmitted giving all of the correct information that should appear on that claim.

- It is important to enter the correct Internal Control Number and Remittance Advice date from the paid claims in blocks 26 and 27 on the adjustment/void form. If this information is not entered exactly, the claim will deny with error message 799 (no history for this adjustment/void).

- When an Adjustment/Void form has been processed it will appear on the RA under **Adjusted or Voided Claims**. The adjustment or void will appear first.

The original claim line will appear in the section directly beneath under the heading **Previously Paid Claims.**

- An Adjustment/Void will generate credit and debit entries that will appear in the Remittance Summary on the last page of the RA as "Adjusted Claims", "Previously Paid Claims" or "Voided Claims".

HEALTH INSURANCE CLAIM ADJUSTMENT/VOID FORM 213 INSTRUCTIONS

*1. ADJ/VOID—Check the appropriate block.

*2. **Patient's Name**

a. **Adjust**—Print the name exactly as it appears on the original claim if not adjusting this information.

b. **Void**—Print the name exactly as it appears on the original claim.

3. **Patient's Date of Birth**

a. **Adjust**—Print the date exactly as it appears on the original claim if not adjusting this information.

b. **Void**—Print the name exactly as it appears on the original claim.

*4. **Medicaid ID Number**—Enter the 13 digit recipient ID number.

5. **Patient's Address and Telephone Number**

a. **Adjust**—Print the address exactly as it appears on the original claim.

b. **Void**—Print the address exactly as it appears on the original claim.

6. **Patient's Sex**

a. **Adjust**—Print this information exactly as it appears on the original claim if not adjusting this information.

b. **Void**—Print this information exactly as it appears on the original claim.

*7. **Insured's Name**— Leave this space blank.

8. **Patient's Relationship to Insured**—Leave this space blank.

9. **Insured's Group No.**—Complete if appropriate or leave space blank.

10. **Other Health Insurance Coverage**—Leave this space blank.

11. **Was Condition Related to:**—Leave this space blank.

12. **Insured's Address**—Leave this space blank.

13. **Date of:**—Leave this space blank.

14. **Date First Consulted You for This Condition**—Leave this space blank.

15. **Has Patient Ever had Same or Similar Symptoms?**—Leave this space blank.

16. **Date Patient Able to Return to Work**—Leave this space blank.

17. **Dates of Total Disability-Dates of Partial Disability**—Leave this space blank.

18. **Name of Referring Physician or Other Source**—Leave this space blank.

19. **For Services Related to Hospitalization Give Hospitalization Dates**—Leave this space blank.

20. **Name and Address of Facility Where Services Rendered (if other than home or office)**—Leave this space blank.

21. **Was Laboratory Work Performed Outside of Office?**—Leave this space blank.

*22. **Diagnosis of Nature of Illness**

a. **Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.

b. **Void**—Print the information exactly as it appears on the original claim.

23. **Attending Number**—Enter the attending number submitted on original claim, if any or leave this space blank.

*24. **Prior Authorization #**—Enter the PA number if applicable or leave blank.

*25. **A through F**

a. **To Adjust**—Print the information exactly as it appears on the original claim if not adjusting the information.

b. **To Void**—Print the information exactly as it appears on the original claim.

*26. **Control Number**—Print the correct Control Number as shown on the Remittance Advice.

*27. **Date of Remittance Advice that Listed Claim was Paid**—Enter MM DD YY from RA form.

*28. **Reasons for Adjustment**—Check the appropriate box if applicable, and write a brief narrative that describes why this adjustment is necessary.

*29. **Reasons for Void**—Check the appropriate box if applicable, and write a brief narrative that describes why this void is necessary.

*30. **Signature of Physician or Supplier**—All Adjustment/Void forms **must** be signed.

*31. **Physician's or Supplier's Name, Address, Zip Code and Telephone Number**—Enter the requested information appropriately plus the seven (7) digit Medicaid provider number. ***The form will be returned if this information is not entered.***

*32. **Patient's Account Number**—(Optional) Enter the patient's correct provider-assigned account number.

Marked (*) items must be completed or form will be returned.

SUBMISSION OF CLAIM AND ADJUSTMENT/VOID FORMS

HCFA 1500 claims and Adjustment/Void transactions for these claims on Form 213 must be submitted to the fiscal intermediary. A supply of form 213 should also be requested from the fiscal intermediary.

CLAIMS PAYMENT SYSTEM

This section is to familiarize the provider with the claims payment system and the design and contents of the Remittance Advice (RA) document which gives the status of submitted claims. The RA plays an important role in communication between the provider, Medicaid,

and the fiscal intermediary. The RA provides a recording of transactions and helps in resolving and correcting possible errors and reconciling paid claims.

REVIEW OF SUBMITTED CLAIMS

When the fiscal intermediary receives a claim, addressed properly for the claim type, it will be reviewed first for missing data.

- If the signature, Recipient Medical Assistance Number, Service Dates, or Provider Name or Number is missing, the claim will be rejected.
- If the claim has missing or incomplete information, the original invoice will be returned with a return letter. The return letter will say why the invoice has been returned.
- Complete the missing or incomplete items on the original invoice and resubmit it. This is the only instance where the original is returned to the provider. A returned claim **will not** appear on the RA because it will not enter the processing system.
- Claim Classification

  All claims that have been processed will fall into one of the following three classifications:

  - Approved (paid) claims
  - Pended claims (Claims in Process)
  - Denied claims

A RA will be sent after each weekly payment cycle in which a new claim is processed. After that, each time activity occurs on a claim, a RA will be issued.

APPROVED PAID CLAIMS

A claim that is correctly completed for a covered service provided to an eligible recipient by an enrolled provider will be paid. It will appear on the RA on the first page, or pages, which list all claims to be paid. If the payment is different from the billed charges, an explanation will appear on the RA.

PENDED CLAIMS (CLAIMS IN PROCESS)

Pended claims (claims in process) are those claims held for in-house review by the fiscal intermediary. If it is determined that a correction by the provider is required, the claim will be denied. If the correction of a claim can be made during the review, the claim will be paid.

A claim may be pended for many reasons. The following are a few examples:

- Errors were made in entering data from the claim into the processing system.
- Errors were made in submitting the claim. These errors can only be corrected by the provider who submitted the claim.
- Critical information is missing or incomplete.

DENIED CLAIMS

A claim will be denied if:

- The recipient is not eligible on the date of service;
- The provider is not enrolled on the date of service;
- Prior authorization is required but not documented;
- The service is not covered by the program;
- It is a duplicate of a prior paid claim;
- The date is invalid or logically inconsistent;
- The program limitations are exceeded; and
- The program minimum requirements are not met.

HOW TO CHECK THE STATUS OF AN INTERNAL CONTROL NUMBER

THE REMITTANCE ADVICE (RA)

The Remittance Advice (RA) informs the provider of the current status of submitted claims.

- On the line immediately below each claim, a code will be printed representing denial reasons, suspense reasons and payment reduction reasons. The only type of claims status that will not have a code is one paid as billed. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims.

- When a medical record number is used, whether it consists of alpha and/or numeric characters, it will appear on the line immediately following the recipient's number.

- A unique 13 digit ID number, called an Internal Control Number, is given to each claim. The Internal Control Number reflected on the RA can be used to track the status of a claim from receipt to final adjudication.

  - The first four digits of the Control Number are the actual year and day the claim was received.

  - The next seven digits tell whether the claim was received on paper or tape and then reflects the batch and sequence numbers of the claim's entry into the processing system.

  - All claims lines on a given claim form will have the same first 11 digits.

  - The **last two numbers** will help determine which line of a claim form is referenced.

Example:		
	1365023456700	refers to first claim line
	1365023456701	refers to second claim line
	1365023456702	refers to third claim line

RECOUPMENT OF PAYMENTS

In situations where the third-party resource payment is received after Medicaid has been billed and made payment, the provider must reimburse Medicaid. Reimbursement must be made **immediately** to comply with regulations. Providers may reimburse Medicaid by forwarding a check or by submitting an adjustment request. When making refunds by check, identify the claim or claims to which the refund is applied. The information necessary to identify these claims will help to reduce additional correspondence. This information can be found on the RA:

- Provider Number
- Date of Payment
- Control Number
- Recipient Name and Identification Number
- Date of Service
- Amount Paid
- Reason for Refund

Refunds should be made only in the case of claims more than two years old. Use adjustments for claims less than two years old.

Refunds should be made payable to the Department of Health and Hospitals and mailed to:

Payment Management Section
Bureau of Fiscal Services
Post Office Box 91117
Baton Rouge, LA 70821-9117

REMITTANCE ADVICE AND HISTORY REQUESTS

Provider participation in the Louisiana Medicaid Program is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. One of those standards is the agreement to maintain any information regarding payments claimed by the provider for furnishing services for a period of five (5) years.

It is the responsibility of the provider to retain all RAs for five (5) years. However, if a provider requests copies of RA or claim histories, the fiscal intermediary will supply this information for a fee.

- No fee will be charged in cases where a check and RA were never received by the provider.
- Requests for RAs never received must be made within three (3) weeks of the RA date or there will be a charge for this information.

If providers are requesting RAs for multiple weeks or a large volume of RAs, the fiscal intermediary will determine whether RA copies or a claim history will be provided.

Requests for RAs or claims histories may be made in writing to:

Unisys
Provider Relations
Post Office Box 91024
Baton Rouge, LA 70821

or by telephoning 1-800-473-2783 or (225) 924-5040. The provider name and number, address, date(s) of the RA being requested, and name of the individual requesting and authorizing the request **must** be included in the request.

Upon receipt of a request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/history will be forwarded to the provider once payment is received.

- The fee for RA's is $0.25 per page.
- Claims history fees are:

1 -- 99 pages	$ 20.00
100—199 pages	$ 38.00
200—499 pages	$ 75.00
500+ pages	$100.00 (or negotiated based on volume)

PROVIDER ASSISTANCE

There are a number of ways in which the provider can assist the Provider Relations staff at the fiscal intermediary in responding to inquiries.

- The Provider Relations telephone unit is for PROVIDERS ONLY, not recipients. If recipients have problems with eligibility, refer them to their eligibility worker at the Medicaid parish office.

- Please ***review and reconcile*** the RA in question BEFORE calling Provider Relations for the status of the claim. Frequently, providers questions are answered if the RA is reviewed thoroughly.

The following menu options are available through the Unisys Provider relations telephone inquiry phone numbers:

- To order printed materials only, such as provider manual's, workshop packets, enrollment packs, Unisys claim forms fee schedules, TPL carrier code lists, and provider newsletter reprints. (To choose this option, press "2" on the telephone keypad.)

- To verify recipient or provider eligibility, Medicare or other insurance information, Primary Care Physician information, or service limits. (To choose this option, press "3" on the telephone keypad.)

- To obtain information regarding KIDMED or CommunityCARE claims or policy questions, or to resolve problem claims, obtain policy clarification, obtain procedure code reimbursement verification, request a field analyst visit, or obtain other information. (To choose this option, press "4" on the telephone keypad.)

Provider Relation will accept faxed information regarding provider inquires. However, faxed claims are not acceptable for processing.

- Providers should have the following information ready when contacting Provider Relations regarding claim inquiries:

  - The correct Medicaid provider number;

  - The recipient's Medicaid ID number;

  - The date of service;

  - Any other information, such as procedure code and billed charge, that will help identify the specific claim in question; and

  - The RA showing disposition of the specific claim in question.

- The provider should get the name of the representative they are speaking to in case a call back is necessary.

- Providers calling with difficult problems requiring extensive research may be asked to submit those requests in writing, along with pertinent documentation, to Unisys' Provider Relations Unit.

SECTION 12
GLOSSARY

SECTION CONTENTS

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GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Elderly and Disabled Adult (EDA) Waiver Manual.

Abuse

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

Abuse

The infliction of physical or mental injury on a recipient by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well-being is endangered. (La. R.S. 14:403.2)

Advocacy

Assuring that the recipient receives appropriate services of high quality and locating additional services not readily available in the community.

Allegation of non-compliance

An allegation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (La. R.S. 40:2009.14)

Allowable Cost

Those costs incurred by the provider agency which are reasonable in amount and are necessary for the efficient delivery of case management services.

Appeal Rights

A due process system of procedures ensuring a recipient or provider agency will be notified of, and have an opportunity to contest certain decisions.

Applicant

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

Assessment

For purposes of case management, the process of gathering and integrating formal/professional and informal information concerning a recipient's goals, strengths, and needs necessary to develop a service plan. For purpose of direct service provider, the process of attending the Interdisciplinary Team (IDT) / Person Centered Planning (PCP), assisting in the formulation of the CPOC, receiving

information about the recipient and developing an individualized direct service plan with specific steps of care to be provided for the recipient. A copy of the CPOC and direct service plan are to be in the home of the recipient.

Bureau of Community Supports and Services (BCSS)

The Bureau within the Department of Health and Hospitals that is responsible for the management and oversight of the Medicaid home and community-based waivers and all case management functions associated with these waivers.

Bureau of Health Services Financing (BHSF)

The Bureau within the Department of Health and Hospitals responsible for the administration of the Louisiana Medicaid Program.

Case Management

Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational, and other support services. This definition adapted from P.L. 100-203(g)(2) and Section 4302A of the *State Medicaid Manual*.

Case Manager

An individual meeting qualifications required by DHH employed by a qualified provider agency who provides case management services.

CMS

The Center for Medicare and Medicaid Services (Formerly known as Health Care Financing Administration-HCFA). The Federal agency in DHHS responsible for administering the Medicaid Program and overseeing and monitoring of the State's Medicaid Program.

COA

Council on Aging.

Complaint

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

Consumer

Another term for client, beneficiary or recipient.

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 limiting of access to a recipient's records to personnel having direct involvement with the recipient subject to federal, state and DHH regulations. The recipient/guardian must give permission for case managers to share information with other agencies.

Corrective Action Plan

Written description of action a provider agency plans to take to correct deficiencies identified by the provider's Quality Improvement Planning Committee or by DHH monitoring staff.

CPOC

Comprehensive Plan of Care.

Department of Health and Hospitals (DHH)

The state agency responsible for administering the Medicaid Program and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services. In this manual the use of the word "department" will mean DHH.

Department of Health and Human Services (DHHS)

The federal agency responsible for administering the Medicaid Program and public health programs.

Department of Social Services (DSS)

The state agency responsible for administering social services including Family Independence Temporary Assistance Program (FITAP), Food Stamps, children's protective services, foster care and vocational rehabilitation services and licensing direct service providers. These direct service providers provide personal care to the Elderly and Disabled Adult Medicaid waiver recipients.

Disabled person

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

Elderly and Disabled Adult (EDA) Waiver

An optional Medicaid program for the elderly and disabled adults established under section 1915 © of the Social Security Act designed to provide services in the community or a least restrictive setting as an alternative to institutional care. The ages are 65 and older and 21 or older who are disabled according to Medicaid standards.

Eligibility

The determination of whether or not a recipient qualifies to receive case

management services based on meeting established criteria for the target or waiver group set by DHH.

Enrollment

A determination made by DHH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other DHH-funded case management services. Also referred to as provider enrollment or certification.

Exploitation

The illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of an aged persons or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 14:403.2)

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. 14:403.2)

Fiscal Intermediary

The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

Follow-Up

A core element of case management and another term for case management monitoring.

Formal services

Another term for professional services.

Fraud

The definition that governs between citizens and government agencies is found in La.R.S. 14:67 and La.R.S. 14:70.01. Legal action may also be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-30). The falsification of documents with intent to gain financial gain.

Health Care Financing Administration (HCFA)

Renamed the Center for Medicare and Medicaid Services formerly known as the HCFA.

Home and Community-Based Services Waiver

A collection of services available in a community setting to enable recipients who qualify for institutional care to remain in their own home setting. These are provided under a special Medicaid program.

Interdisciplinary (ID) Team Meeting

The group of professionals involved in assessing the needs of a waiver recipient and making recommendations in a team staffing for services or interventions targeted at those needs. This meeting is necessary to formulate the CPOC. The ID team may consist of the case manager, direct service provider, recipient, members of the recipient's family or supports and other professionals who know him best to formulate a CPOC for service delivery to the recipient.

Informal Services

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

Institutionalization

Placement of a recipient in any inpatient facility including a hospital, group home for the mentally retarded, nursing facility, or psychiatric hospital.

Intake

The screening process consisting of activities necessary to determine the need and eligibility for Medicaid provided services, including case management services.

Licensing

A determination by the DHH/BCSS that a case management agency meets the state requirements to provide coordination of services for the recipient. The direct service provider is licensed by the DSS.

Linkage

A core element of case management defined as implementation of the service plan and arranging of a continuum of formal/professional and informal services to be provided to the recipient. The case manager shall provide the recipient with knowledge of services available and assist the recipient in obtaining those services.

Medicaid

A federal-state financed entitlement program which provides medical services primarily to low-income individuals under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Card (MEC)

A medical eligibility card (MEC) issued to each eligible recipient and/or family each month.

Medicaid Program/Medicaid

Medical assistance provided under the State Plan approve under Title XIX of the Social Security Act.

Medically Needy Program (MNP)

An optional Medicaid eligibility category designed to provide coverage when an individual's or family's income and/or resources are sufficient to meet basic needs in a categorical assistance program but not sufficient to meet medical needs according to applicable MNP standards.

Medicare

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

Medicaid Management Information System (MMIS)

The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

Minimal Harm

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

Neglect

The failure, by a care giver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his 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. 14:403.2)

Nursing Facility (NF)

A Nursing Facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the social Security Act. Provides Long Term Care and placement for those individuals who meet the eligibility requirements.

Office of Mental Health (OMH)

The Office in DHH responsible for services to the mentally ill.

Office of Public Health (OPH)

The Office in DHH responsible for personal and environmental health services.

Personal Outcome

Program evaluation that measures and focuses on the items, issues and services that matter most to that individual. Each individual has the opportunity to identify their own meaning and personal outcome.

Person-Centered Assessment

The process of gathering and integrating formal and informal information relevant to the development of an individualized CPOC.

Presumptive Eligibility (PE)

A medical program which provides limited Medicaid coverage for pregnant women. Presumptive Eligibility covers ambulatory (outpatient) prenatal services and cannot exceed 45 days per Presumptive Eligibility certification.

Provider

An agency furnishing targeted or waiver case management services under a provider agreement with DHH. Also referred to as provider agency.

Provider Agreement

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

Provider Enrollment

Another term for enrollment.

Quality Management Monitoring Unit

DHH/ BCSS Quality Management staff responsible for performing on-site reviews of case management providers to determine compliance with Medicaid policies and procedures.

Reassessment

A core element of case management defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and revising the overall service plan.

Recipient

The individual receiving services, who may chose to receive assistance and delegate a responsible party or family/guardian to assist. All references to recipient includes the parent or guardian if the recipient has been interdicted or is a minor.

Regional BCSS

DHH's nine Regions that BCSS is represented by a Regional Office.

Representative Payee

A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the

Medicaid-eligible recipient.

Responsible Party

Any individual/group designated by a Medicaid-eligible to act as official agent in dealing with DHH and/or a provider. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Secretary

The Secretary of the Department of Health and Hospitals or any official to whom (s)he has delegated the pertinent authority.

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. 14:403.2)

Service Plan

The written agreement that specifies the long-range goals, short-term objectives, specific action steps or services, assignment of responsibility, and time frames for completion or review by the direct service provider.

Spend-down

A term used to describe a group of Medically Needy recipients whose income is above the MNP income eligibility standards but they may qualify for MN assistance on the basis that countable income has been spent or is obligated to pay unpaid medical expenses.

Sexual abuse

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

Slot

An opportunity for services by the Title XIX Medicaid Waiver to eligible applicants who meet the requirements for institutional care

Targeted Case Management

Term for case management but specific to population group(s) and/or geographical area(s). This is an optional service of the Medicaid Program authorized by Section 1915(g) of the Social Security Act. The EDA Waiver is one of the five targeted groups.

Third Party Liability (TPL)

Refers to the responsibility of another payer (Medicare, insurance, etc.) to pay benefits for services before Medicaid pays. Medicaid is generally the payer of last resort.

Transition

Refers to the steps to support the passage of the recipient to existing formal or informal services to the extent appropriate or out of services completely.

Trivial Report

A report of an allegation that an incident has occurred to a consumer or consumers that causes no physical or emotional harm and has no potential for causing harm to the recipient or recipients. (La. R.S. 40:2009.14)

Waiver

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

SERVICES AVAILABLE TO MEDICAID ELIGIBLE CHILDREN

APPENDIX A

The Department of Health and Hospitals offers an array of health care services to children under the age of twenty-one (21) through the Early Periodic Screening Diagnostic, and Treatment (EPSDT) Program. Please review this list of services and other pertinent information on the following pages so you can make referrals for other health care services as appropriate. We are also requesting that you provide a copy of the services list to your patients as necessary. The list of services available is on the next page.

Services Available to Medicaid Eligible Children Under 21

If you are a Medicaid recipient under the age of 21, you may be eligible for the following services:

- Doctor's Visits
- Hospital Services (inpatient and outpatient)
- Lab and X-ray Tests
- Family Planning
- Home Health Care
- Dental Care
- Rehabilitation Services
- Prescription Drugs
- Medical Equipment, Appliances and Supplies (DME)
- Case Management
- Speech and Language Evaluations and Therapies
- Occupational Therapy
- Physical Therapy
- Psychological Evaluations and Therapy
- Podiatry Services
- Optometrist Services
- Hospice Services
- Extended Home Health Services
- Residential Institutional Care or Home and Community Based (Waiver) Services
- Medical, Dental, Vision and Hearing Screenings: Periodic and Interperiodic
- Immunizations
- Eyeglasses
- Hearing Aids
- Psychiatric Hospital Care
- Personal Care Services
- Audiological Services
- Transportation: Ambulance Transportation, Non-ambulance Transportation
- Addictive Disorders
- Chiropractic Services
- Prenatal Care
- Certified Nurse Midwives
- Certified Nurse Practitioners
- Mental Health Rehabilitation
- Mental Health Clinic Services
- Appointment Scheduling Assistance (Contact KIDMED at 1-877-544-9544)

Any other medically necessary health care, diagnostic services, treatment, and other measures which are covered by Medicaid, which includes a wide range of services not covered for recipients over the age of 21 are also covered.

Medicaid recipients under age 21 who are on the request for services registry for the MR/DD waiver may be eligible for case management services. To obtain this service, Statistical Resources, Inc. must be contacted at 1-800- 364- 7825.

Other services may be accessed by calling KIDMED at 1-877-455-9955 toll-free. Deaf or hard of hearing recipients should call the TTY number, 1-877-544-9544 toll-free. Recipients who

have a communication disability or are non-English speaking may have someone else call KIDMED and the appropriate assistance will be provided.

Some of these services must be approved by Medicaid in advance. The medical provider should be aware of which services must be pre-approved and can assist you in obtaining the services. Also, KIDMED can assist the medical provider or recipient with information as to which services that must be pre-approved.

Whenever health treatment or additional services are needed, an appointment for a screening visit may be obtained by contacting KIDMED. To schedule a screening visit, contact KIDMED at 1-800-259-4444 (toll-free) or 928-9683, if you live in the Baton Rouge area. Deaf or hard of hearing recipients should call the TTY number 1-877-544-9544 (toll-free). Recipients, who have a communication disability or are non-English speaking, may have someone else call KIDMED and the appropriate assistance will be provided. Screening visits can also be recommended by any health, developmental, or educational professional.

Louisiana Medicaid encourages recipients to contact the KIDMED office and obtain a KIDMED provider so that you may be better served.

Recipients who live in a CommunityCARE parish, should contact their primary care physician for assistance in obtaining any of these services or contact KIDMED at 1-877-455-9955 toll-free.

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Frederick P. Cerise, M.D., M.P.
SECRETARY

September 22, 2004

BCSS-ADM-04-006
BCSS-C-04-021
BCSS-P-04-018

TO: **All Medicaid Home and Community-Based (HCB) Waiver Direct Service Providers**

FROM: **Barbara C. Dodge, MA FAAMR**
Director

RE: **Clarification of requirements for HCB Waiver Direct Service Providers regarding Individualized Back Up Plans and Emergency Evacuation Response Plans**

This memo will serve as clarification of requirements for Medicaid HCB Waiver Direct Service Providers regarding Individualized Back Up Plans and Emergency Evacuation Response Plans. HCB Waiver Direct Service Providers are required to have functional Individualized Back Up Plans and Emergency Evacuation Response Plans that are consistent with the participant's Comprehensive Plan of Care (CPOC).

HCB Waiver Direct Service Provider agencies shall possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety outlined in the approved CPOC.

For people with disabilities who need some form of assistance to accomplish life's daily tasks, being without the personal assistance and supports they need can be a frightening and intimidating experience. Without the necessary assistance and supports, the participant's physical and/or emotional health and safety can be negatively impacted. Even worse, the participant may experience loss of dignity, independence and control over his/her life and services. Well thought out backup plans that are prepared before such occasions arise, are not only required, but are essential to the overall well-being, safety and peace of mind of the participant.

Backup plans cover situations that may occur from time to time when direct support workers are absent, unavailable or unable to work for any reason. The participant's Support Coordinator (Case Manager), through a person-centered process, is responsible for working with the participant, his/her family, friends and providers during initial and subsequent annual CPOC planning meetings to establish plans to address these situations. Backup plans must be updated

annually, or more frequently as needed, to assure information is kept current and applicable to the participant's needs at all times.

The Support Coordinator shall assist the participant and his/her circle of support to identify individuals who are willing and able to provide a backup system during times when paid supports are not scheduled on the participant's CPOC. When supports are scheduled to be provided by the direct service provider, providers must have back up systems in Place. It is unacceptable for the Direct Service Provider to use the participant's informal support system (i.e., friends and family) as a means of meeting the agency's individualized backup plan, and/or emergency evaluation response plan requirements. Families and others identified in the participant's circle of support may elect to provide back up but this does not exempt the provider from the requirement of providing the necessary staff for back up purposes.

The backup plan must include detailed strategies and person-specific information that addresses the kind of specialized care and supports needed by the participant, as specified in their individualized Comprehensive Plan Of Care (CPOC).

The agency must have in place policies and procedures that outline the protocols the agency has established to assure that backup direct support staff are readily available, that lines of communication and chain-of-command have been established, and that procedures for dissemination of the backup plan information to participants and Support Coordinators are in place. Protocols outlining how and when direct support staff are to be trained in the care and supports needed by the participant must also be included. Note: Training for workers must occur **prior** to the worker being solely responsible for the support of the participant.

Next, an Emergency Evacuation Response Plan must be developed and included in the participant's CPOC. An Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts. The Emergency Evacuation Response Plan must include at a minimum the following components:

- Individualized risk assessment of potential health emergencies, geographical and natural disaster emergencies, as well as potential for any other emergency conditions;

- A detailed plan to address participant's individualized evacuation needs, including a review of individualized backup plans;

- Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security, establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and

- Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post emergency protocols. Note: Training for direct support staff must occur **prior** to worker being solely responsible for the support of the participant and participants must be provided with regular, planned opportunities to practice the Emergency Evacuation Response Plan.

Due to the requirements of HCBS Waivers to ensure the health and welfare of Waiver participants, Direct Service Providers who are deemed to be out of compliance in the provision of necessary supports will be removed from the Freedom of Choice listing and /or sanctioned up to and including exclusion from the Medicaid Program.

CC: All Case Management (Support Coordination) Agencies
BCSS Regional Offices
BCSS State Office Staff
All Policy and Procedure and Service Manuals

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

July 30, 2004

BCSS-C-04-019
BCSS-P-04-015
BCSS-ADM-04-005

MEMORANDUM

TO: Contracted and Non-Contracted Case Management Agencies
Direct Service Provider Agencies
BCSS Regional Offices

FROM: Barbara C. Dodge, Director

RE: Clarification of Documentation Procedures

This will serve to clarify proper documentation procedures for staff to use in recording activities for recipients of waiver services.

Documentation in case records provides an ongoing "picture" of the progress toward achieving outcomes and the basis for decisions and recommendations for supportive services. For this reason, documentation of activities is not linked to minute increments, but rather describes the activity over a period of time.

While HIPAA requires billing to be recorded in 15-minute increments, this is not necessarily a requirement of documentation. Unless the activity only takes 15 minutes, such as administration of medication, then documentation would cover the period of time the activity took place. Documentation must be completed at the end of each shift for each service delivered.

An example of an adequate progress note would be a shopping trip with the direct support worker to the mall that occurs over a 3 hour time period, where the time is documented in a summary. Staff **would not** be required to document every 15 minutes to describe the ongoing activities. The adequate progress note could be done in a summary, describing the time the person left for the shopping trip, who accompanied them, possibly purchases made, a meal or snack eaten, a movie that was attended, the time they returned home and progress toward their personal outcome. Remember, however, that critical incidents, per BCSS policy, must always be included as a part of documentation.

Documentation is not intended to be intrusive or an embarrassment to anyone. It should describe the quality and quantity of services rendered, as well as provide accountability for the agency.