CASE MANAGEMENT SERVICES

PROVIDER MANUAL

LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING

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UNISYS

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1.0 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 Centers for Medicare and Medicaid Services (CMS) (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 somewhat more liberally defined. 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.

2.0 COMPONENTS OF MEDICAID

2.1 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 the services or supplies provided to the recipient.

2.2 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.

2.3 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 to identify eligible recipients to providers of medical care services.

A detailed explanation of the Medicaid Card can be found in the *Eligibility* section of this manual.

3.0 BUREAU RESPONSIBILITY

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

- Administering the program including developing rules, regulations, 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; and
- Conducting prepayment and post payment review.

4.0 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.

4.1 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.

4.2 ADMINISTRATIVE DUTIES

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

- Process Claims;
- 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.

5.0 STANDARDS FOR PARTICIPATION

Provider participation in the Louisiana Medicaid Program is entirely voluntary. State laws, rules and regulations, department policies and practices and federal laws define certain standards for providers who choose to participate. Some of these standards are listed as follows:

- Provider agreement and enrollment with BHSF;
- Agreement to Electronic Funds Transfer (EFT), also known as direct deposit, of Medicaid 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 BHSF 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,

NOTE: ***Records must be retained for five (5) years and be furnished as requested, to BHSF, its authorized representative, representatives of DHH's or the state Attorney General's Medicaid Fraud Control Unit.***

- 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***.

There are a number of other standards of participation. It is the providers responsibility to know these standards.

6.0 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 laws, rules, regulations and policies applicable to the Louisiana Medicaid Program. This agreement also certifies that information contained on the claim form is true, accurate, complete and adequately documented.

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ELIGIBILITY

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2.0 ELIGIBILITY

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

2.01 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.

2.02 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. 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 may qualify for under the broad categories listed above.

2.03 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).

COMMUNITY CARE 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.

LaCHIP

Congress passed Public Law 105-33 in 1997 to establish a new Title XXI under the Social Security Act called the State Children's Health Insurance Program (SCHIP).

In May 1998, the Louisiana Legislature passed Act 128, which authorized the Louisiana Child Health Insurance Program (LaCHIP) as an expansion of the existing Medicaid Program. This program enrolls children under the age of 19.

2.1 VERIFYING ELIGIBILITY

2.1.1 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.

2.1.2 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 toll-free telephone number (800) 776-6323.

2.1.3 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

2.1.4 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 your 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.

2.4 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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3.0 PROVIDER RESPONSIBILITIES

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, CMS (formerly known as HCFA), and Federal and State governments.

3.0.1 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 LSARS 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 are 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 provider's enrollment for failure to comply with MAPIL terms or other Medicaid policies. Additionally, on September 20, 1999, new regulations were promulgated related to provider conduct and sanctioning. These new regulations should be reviewed by all providers. The new regulations can be reviewed in the *Louisiana Register*, Vol.25, No. 9, September 20, 1999, pages 1630-1650.

3.0.2 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;
- 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***; and
- **Records retention for five (5) years** and furnishing records as requested, to the Bureau, its authorized representative, representatives of DHH 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.

3.0.3 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.

3.1CASE MANAGEMENT PROVIDER ENROLLMENT PROCEDURES

Providers who wish to participate in the Louisiana Medicaid Program as a case management agency should contact the DHH Licensing Section to request an enrollment packet. The agency should complete the packet and return it to the Bureau of Community Supports and Services (BCSS). Enrollment will be approved if the agency meets all qualifications, licensure requirements and the standards for participation in the Louisiana Medicaid Program. For answers to questions regarding case management provider enrollment and contract participation requirements, contact the BCSS Licensing Section.

- Each enrolling agency must enter an agreement with the Louisiana Medicaid Program. The agreement requires that agencies adhere to regulations, including Electronic Funds Transfer (EFT) of Medicaid payments and the requirements contained in this provider manual.

- Each enrolling agency must designate a representative and authorize the representative to enter into the provider agreement. A copy of the affidavit identifying the name of the representative must be provided to BCSS.

- Enrollment packets may be obtained from the following address:

  DHH Bureau of Community Supports and Services
  Licensing Section
  446 North 12th Street
  Baton Rouge, Louisiana 70802-4613

- Completed forms for ***each separate target population to be served and DHH region*** to be served should be submitted to BCSS. The following information should be included in the returned packet:

  - A completed form PE-50.

  - Disclosure of Ownership and Control Interest Statement (HCF-1513).

  - Agencies contracted to provide case management services must provide a letter of credit on bank letterhead from a federal bank certified by the Federal Office of Comptroller and Currency for at least 10% of the total contract amount but in no case less than $50,000 as proof of adequate finances. In lieu of a letter of credit, the case management agency may choose to have a 10% retainage of the monthly Medicaid payments.

  - Proof of general liability insurance of $150,000 and professional liability

insurance of $150,000. The certificate holder will be the Department of Health and Hospitals.

- If additional information is required, the applicant will be notified. Notification of provider enrollment in the Louisiana Medicaid Program is the assignment of a provider number to be used when submitting claims.

3.1.1 CASE MANAGEMENT ENROLLMENT TO SERVE ADDITIONAL POPULATIONS

An enrolled and contracted case management agency must request a separate enrollment and Medicaid provider number for each additional target or waiver group before providing services. Approval of enrollment is subject to each of the provider enrollment requirements and procedures to provide case management services for the additional target or waiver groups for each DHH Administrative Region.

3.1.2 RESTRICTED ENROLLMENT

In accordance with Section 4118(I) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, Public Law 100-203, the Department may restrict enrollment and service areas of agencies that are enrolled in the Medicaid Program to provide case management services to:

- High Risk Pregnant Women
- MR/DD Waiver Recipients
- Infants and Toddlers With Special Needs
- HIV Positive Individuals
- Nurse Home Visits for First Time Mothers
- EPSDT
- Elderly and Disabled Adults Waiver Recipients
- Children's Choice Waiver Recipients

These targeted groups may be restricted by DHH in order to ensure that the case management agencies available to these targeted groups and any subgroups are capable of ensuring that the targeted recipients receive the full range of needed services.

3.1.3 LICENSURE

In order to enroll as a DHH provider of case management services, each case management agency must also apply for licensure or be currently licensed to provide case management services/service coordination in the state of Louisiana.

- All licenses for DHH funded case management services must be issued by

BCSS.

- Licensure for this program is provided by:

  Bureau of Community Supports and Services
  Licensing Section
  446 North 12th Street
  Baton Rouge, Louisiana 70802-4613

  A packet of information outlining the licensure requirements may be obtained by contacting the BCSS Licensing Section.

- Applicant agencies should apply for licensure and enrollment for Medicaid case management or case management funded by other DHH funds concurrently to expedite the licensure and enrollment process. Agencies that will be providing Case Management funded by sources other than Medicaid will be considered only for licensure (not Medicaid enrollment).

- A license will not be issued to a case management agency until the agency is approved by BCSS to provide case management services to a specific target or waiver group in a specified DHH region.

- Changes in ownership, agency name, and/or physical location must be reported to the BCSS Licensing section. Please refer to sections Change in Ownership (CHOW), Case Management Change of Ownership (CHOW) and Case Management Change of Address/Enrollment Status in the Case Management Manual for more detailed information.

3.1.4 PROVIDER ENROLLMENT SITE VISIT

When the agency has completed documentation of each of the enrollment requirements listed in this section and on the checklist, the agency must submit the completed PE-50 form and disclosure of ownership form to the Bureau of Community Supports and Services Licensing Section.

- The applicant agency will be contacted by the BCSS Regional Office to schedule a site visit upon receipt of the completed forms.

- Compliance with each of the enrollment requirements listed in this section and on the enrollment checklist will be verified by the BCSS Regional Office staff during a site visit.

- If any of the enrollment requirements are not met at the time of the site visit, the applicant agency will be notified in writing within 10 days as to the areas needing correction.

- The applicant agency must promptly submit appropriate documentation of corrective action taken.

- If the agency fails to submit the required documentation of corrective action taken within 30 days of the notice, a recommendation will be made to the Medicaid Program to reject the application for enrollment or terminate the enrollment of an existing provider.

- If the agency submits the required documentation of corrective action, the BCSS Regional Office will verify that the deficiencies are corrected.

- A follow-up site visit may be conducted to ensure that the agency is in complete compliance with all of the enrollment requirements. Once the case management agency meets all of the enrollment requirements, the BCSS Licensing Section will submit the necessary documents with a recommendation on enrollment to the Medicaid Provider Enrollment Unit

NOTE: The case management agency should not submit documents directly to the Medicaid Provider Enrollment Unit as this will delay the enrollment process.

3.1.5 ENROLLMENT NOTIFICATION

- If the case management agency is determined to be eligible for enrollment or re-enrollment, the agency will be notified in writing by the Provider Enrollment Unit of :

  - The Medicaid Program of the effective date of enrollment or re-enrollment. The effective date will be the date of certification by BCSS.

  - The Medicaid case management provider number for each office site. This number is a unique identification number which must be utilized by the agency in contacts with the Medicaid Program, the Fiscal Intermediary, and for billing.

  - DHH region or target or waiver group approved.

- If BCSS determines that the case management agency does **not** meet the

enrollment requirements, the agency will be notified in writing of the deficiencies needing correction.

- The applicant/provider will receive **written notification** from the Medicaid Provider Enrollment Unit of any adverse action taken.

- If enrollment or re-enrollment is denied, the agency may not reapply for at least 6 months to be re-considered for enrollment.

NOTE: If the case management agency does not meet requirements specified in this section which are applicable to another target or waiver groups or DHH region the agency wishes to serve or is serving, the agency will be determined ineligible to provide any DHH-funded case management services to the other target or waiver group or DHH region

3.1.6 CHANGE IN OWNERSHIP (CHOW)

A change in ownership (CHOW) occurs whenever a transfer of stock or a change in profit sharing occurs. The provider must notify the Bureau's Provider Enrollment Unit in writing at the above address prior to any such change in ownership. A CHOW which involves a five percent (5%) or more change in stock ownership or profit sharing requires a new provider number. A CHOW requires a new provider enrollment packet be completed and a new Case Management License application and a $600.00 fee be turned in to the BCSS Licensing Section. To obtain the packet, send a written request to BCSS Licensing Section and a $25.00 fee in the form of check or money order made payable to DHH.

The packet contains all necessary documents to initiate a CHOW. A CHOW requires:

- A new provider enrollment packet must be completed and returned to BCSS Licensing Section.

- A new case management license application, including the $600 licensing fee in the form of check or money order made payable to DHH, must be sent by the new owner to the BCSS Licensing Section.

- A new provider number will be assigned as the previous provider number should not be used past the date of sale.

- Another onsite visit by the BCSS Regional Office to ensure that all BCSS procedures are in place.

- A new case management license will be issued upon receipt of verification from

BCSS Regional Office that the agency meets all licensing requirements.

- New freedom of choice forms must be completed for all recipients.

NOTE: Services cannot be provided nor billed on the new number until the new provider has met all requirements for enrollment as a Case Management agency.

Change of Address/Enrollment Status

- Providers who have changes in enrollment information should notify in writing:

  UNISYS
  Provider Enrollment
  P.O. Box 80159
  Baton Rouge, Louisiana 70898-0159
  (225) 923-8510

  AND

  Bureau of Community Supports and Services
  Case Management Administrator
  446 North 12th Street
  Baton Rouge, Louisiana 70802-4613
  (225) 219-0200

- Changes that must be reported are:

  - Any change in physical location
  - Any change in mailing address
  - Any change in telephone number
  - Any change in ownership (See CHOW)
  - Any change in account information affecting EFT

- Any name change (not ownership) and/or physical location must also be reported to the BCSS Licensing Section by sending a new case management license application and $25.00 fee in the form of check or money order made payable to DHH. Upon receipt of the new application and fee, a new license will be issued.

Giving advance notification of address changes will allow correspondence and rejected claims to be delivered to the appropriate providers in a timely manner. The address and telephone numbers to report changes can be found above.

- Providers who change their group affiliation should notify Provider Enrollment in writing to eliminate the possibility of payments being delivered to the wrong provider/group.

3.1.7 ENROLLMENT REQUIREMENTS FOR MEDICAID PROVIDERS

An applicant or currently enrolled agency must meet each of the enrollment requirements to be approved for enrollment as a Medicaid or other DHH-funded case management provider. The applicant must:

- Have demonstrated direct experience in successfully serving the target population or waiver group and demonstrated knowledge of available community services and methods for accessing them including each of the following:

  - Have established linkages with the resources available in the community relevant formal and informal service providers and community agencies.

  - Maintain a current resource file (updated annually) of formal and informal medical, mental health, social, financial assistance, vocational, educational, housing and other support services available to the unique needs of the target population or waiver group within the community.

  - Demonstrate knowledge of the eligibility requirements and application procedures of federal, state, and local government assistance programs which are applicable to recipients served.

  - Directly employ a sufficient number of qualified case managers and supervisory staff with consideration of: the geographical area served; cultural diversity, number and needs of the recipients served; and, the intensity of the services. Prior to startup the agency must complete and submit capacity reports to the Case Management Administrator.

- Possess a current license to provide case management/service coordination in Louisiana **or** written proof of application for BCSS licensure.

- Demonstrate administrative capacity to provide all core elements of case management and ensure effective case management services to the target population or waiver group in accordance with BCSS requirements as evidenced by a review of the following:

  - Documentation of identification, composition, and responsibilities of the governing body, written minutes of formal meetings and by-laws in accordance with licensing regulations.

- Written policies and procedures on: employment and personnel including job descriptions; hiring practices including a policy against discrimination; employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances; staffing and staff coverage plan; professional ethics which comply with the *Louisiana Code of Governmental Ethics*.

- Written procedures for the maintenance, security, supervision, confidentiality, organization, transfer, and disposal of records.

- Agency's functional organizational chart which depicts all lines of authority.

- Written program philosophy, goals, services provided, and eligibility criteria that defines each target or waiver group to be served; schedule of any fees charged to non-DHH recipients; methods of obtaining feedback from recipients.

- Written polices and procedures that identify and protect the recipient's rights and procedures for informing the recipient/guardian of these rights both verbally and in writing in language the recipient/guardian is able to understand.

- Written grievance procedures.

- Written policies and procedures regarding abuse and neglect as defined by DHH regulations and state and federal law.

- Maintain a 24 hour toll free number; shall be manned by a person.

- Assure that each case manager is directly employed by the case management agency in accordance with federal Internal Revenue Service (IRS) regulations requiring that a W-2 form be submitted on each employee. Each case manager and supervisor must be employed (not contracted) at least forty (40) hours per week.

- Assure that each case manager and case manager supervisor comply with each of the following:

  - Satisfactorily completes an orientation and training program in the first ninety (90) days of employment.

- Satisfactorily completes case management related training on an annual basis to meet at least minimum BCSS training requirements described in Section 6.

- Satisfactorily completes any case management training mandated by DHH.

- Possess adequate case management abilities, skills and knowledge to adequately perform each core element of case management.

NOTE: The provision of, arranging for, and payment for such training is the responsibility of the case management agency.

- Have a written plan to determine the effectiveness of the program including a Quality Improvement Plan (QIP) approved by BCSS.

- Maintain a separate record on each recipient which includes complete documentation of all of the core elements of case management and required case management activities as described in Section 5.

- Agree to safeguard the confidentiality of the recipient's records in accordance with DHH regulations and federal and state laws and regulations governing confidentiality.

- Assure each eligible recipient's right to: elect to receive case management as an optional service; terminate such services; elect to choose a case management agency (recipients may change every 6 months), a qualified case manager, and other service provider(s); and elect to change case management agency, case manager and service provider(s) consistent with Section 1902a(23) of the Social Security Act.

- Assure that the agency and case managers will not provide case management and Medicaid reimbursed direct services to the same recipient(s).

- Have adequate financial resources, establish a system of business management and staffing, and demonstrate fiscal accountability to assure maintenance of complete and accurate accounts, books, and records in keeping with generally accepted accounting principles that is capable of:

  - Submitting a preliminary or current detailed budget for case management.

- Adequately funding required qualified staff and services.
- Providing documentation of services and costs.
- Assure regular recording of agency finances and agree to provide BCSS with a copy of the report of an annual audit conducted by a certified public accountant in accordance with generally accepted accounting principles when an agency has been operating for a full 12 months.
- Agrees not to permit any public funds to be paid, or committed to be paid, to any person to which any of the members of the governing body, administrative personnel, or members of the immediate families of members of the governing body or administrative personnel have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost.
- Purchase and maintain adequate and appropriate general liability insurance for the protection of recipients, staff, facilities, and the general public.

- Maintain a written non-discriminatory policy for intake screening, including referral criteria, transition, and closure including a plan for maintenance of needed services after case closure when applicable.
- Assure that services will be provided in a culturally sensitive manner.
- With the recipient's permission, agree to maintain regular contact, share information and coordinate medical services with the recipient's primary care or attending physician or clinic.
- Fully comply with the *Code of Governmental Ethics*.
- Demonstrate the capacity to participate and agree to participate in a data-base program and provide up-to-date data to the Regional Office and/or Program Office on a weekly basis via electronic mail. A data-base program will be provided without charge to the agency.
- The computer system must meet the following minimum criteria:
    - IBM compatible PC with a Pentium III MHZ processor
    - 128 MB of RAM memory (minimum)
    - 25 MB free hard drive space
    - Color Monitor capable of 800 X 600 resolution

- Printer compatible with hardware and software required
- Modem (56k or faster)
- CD ROM
- Windows 98 Operating System (minimum)
- An Internet account with E-mail and Web-browser software
- The software required is Corel Word Perfect 8 or above
- The Contractor is expected to maintain hardware compatible with current required software.

- Demonstrate successful experience with delivery and/or coordination of services for pregnant women; have a working relationship with a local obstetrical provider/acute care hospital providing deliveries for 24-hour medical consultation; have a multi-disciplinary team consisting, at minimum, of: a physician; primary nurse associate or certified nurse manager; registered nurse; social worker; and nutritionist.

  All team members must meet DHH licensure and perinatal experience requirements applicable to high-risk pregnant women and procedures in order to provide case management services to an additional target population.

- Satisfactorily complete a one-day training as approved by DHH HIV Program Office when required.

- An enrolled case management agency must request a separate enrollment and Medicaid provider number for each additional target or waiver group before providing services. Approval of enrollment is subject to the above-described enrollment requirements and procedures to provide case management services for the additional target population.

  - Applicants will be subject to review by BCSS to determine ability and capacity to serve the target population and a site visit to verify compliance with all provider enrollment requirements prior to a decision by the Medicaid Program on enrollment as a case management agency or at any time subsequent to enrollment.

- Enrolled case management agencies will be subject to review by the BCSS and the U.S. Department of Health and Human Services to verify compliance with all provider enrollment requirements at any time subsequent to enrollment.

- Providers requesting enrollment in the Nurse Home Visitation for First Time Mothers Program must meet additional criteria. All new providers must submit a written request to the Bureau of Community Supports and Services identifying

the case management population and the region they wish to serve. A new provider must attend a Provider Enrollment Orientation prior to obtaining a provider enrollment packet. The bureau will offer orientation sessions at least twice per year. Enrollment packets will only be accepted for service delivery in those DHH regions that currently have open enrollment for case management agencies interested in serving certain targeted populations.

- If BCSS determines that the case management agency does **not** meet the enrollment requirements, the agency will be notified in writing of the deficiencies needing correction.

  - The applicant/provider will receive **written notification** from the Medicaid Provider Enrollment Unit of any adverse action taken.

  - If enrollment or re-enrollment is denied, the agency may not reapply for at least 6 months to be re-considered for enrollment.

*NOTE: **If the case management agency does not meet requirements specified in this section which are applicable to another target or waiver groups or DHH region the agency wishes to serve or is serving, the agency will be determined ineligible to provide any DHH-funded case management services to the other target or waiver group or DHH region.***

SECTION 4
OVERVIEW AND ELIGIBILITY OF TARGET AND WAIVER POPULATIONS

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4.0 DEFINITION OF CASE MANAGEMENT

4.01 TARGETED CASE MANAGEMENT

This definition is adapted from Public Law 100-203(g)(2) and Section 4302A of the State Medicaid Manual. DHH defines case management as **services provided to eligible recipients to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services**.

4.02 INFANTS AND TODDLERS

The report accompanying Public Law 99-457 and reauthorized as 102-119 defines case management under Part H for infants and toddlers with special needs as "an active, ongoing process of continuously seeking the appropriate services or situations to benefit the development of each infant or toddler being served for the duration of each child's eligibility."

4.1 PHILOSOPHY OF CASE MANAGEMENT

Case management is a professional service involving a set of logical steps and a process of interaction within the community service network which assures that recipients receive services and supports in a manner that responsively, effectively and efficiently leads to the personal outcomes. Recipients requiring case management have multiple service needs and require a variety of community resources.

4.1.1 GOALS OF CASE MANAGEMENT

The goals of case management are to foster independence and self-sufficiency, and ensure the recipients' health, safety, and well-being in the least restrictive environment. The ultimate goal is achieving and maintaining the recipients' desired personal outcomes. This is accomplished through the coordination of paid and generic community services, and other natural support systems.

- These goals are often achieved by preventing inappropriate institutionalization or reducing periods of institutionalization in acute and long-term care settings.

High Risk Pregnant Women

The goal for High Risk Pregnant Women is:

- To reduce the risk of a poor birth outcome.

Nurse Home Visitation For First Time Mothers

The goals for Nurse Home Visitation For First Time Mothers are:

- To improve outcomes of pregnancy,
- To improve infant/child health and development, and
- To improve mother's own personal life-course development

EPSDT Targeted Population

The goal of targeted EPSDT case management is:

- To assist a Medicaid eligible child to access any array of health care services for which they may be eligible.

Many recipients and their care givers cannot access or unravel the complex health care and social services delivery system. Case managers help recipients and care givers make informed decisions based on the recipients' needs, abilities, resources and personal preferences. Effective case management is designed to coordinate care and services in an otherwise complex system.

Other terms for case management are family service coordination, service coordination, care coordination, and care management.

The Department of Health and Hospitals utilizes a "service broker" model of case management. The case manager is a "gate opener", helper, enabler, and advocate for the recipient, and functions in a manner that is person-centered and person-empowering.

CASE MANAGEMENT VALUES AND PRINCIPLES

The underlying values and principles listed here provide the foundation upon which licensed case management services are provided.

- The focus of case management services must be on:
  - Identifying and utilizing the recipient's strengths to cope with their condition or disabilities;
  - Understanding the recipient's defined and prioritized personal outcomes; and

- Assisting the recipient to implement strategies to attain or maintain these personal outcomes.

- The principle of informed decision-making is central to case management. Decisions and choices are meaningful when three dimensions are present: experience, support and creativity. Personal outcomes are achieved when the following occurs:

  - Recipients are given a range of experiences from which to make choices.

  - Recipients are provided with ongoing support while learning from experiences.

  - Professionals, providers and guardians are as creative as possible when developing the array of choices.

  - The relationship between the case manager and the recipient is primary and essential to service provision.

  - Case management must be accessible to the recipient, family, guardian, and others associated with the recipient. Contacts with recipients receiving case management services must take place in settings and at times most convenient to them during, as well as outside, normal business hours.

  - The community must be viewed as a potential resource, not as an obstacle.

  - Case management services must be recipient driven.

  - The recipient's self-determination must be maximized to the fullest extent possible.

  - Case management services must be culturally sensitive.

  - Recipients with severe developmental disabilities can learn, grow, and change.

  - When serving children, the family unit is included in the process of developing outcomes.

4.2 PHILOSOPHY OF PERSONAL OUTCOMES

4.2.1 PERSONAL OUTCOMES

Personal outcomes form the core of person centered case management. According to the Council on Quality and Leadership in Support of People with Disabilities, personal outcomes relate to the principle expectations in a person's life and what they require from the services and supports they receive to meet these expectations. These outcomes are based on gathering information from all relevant sources such as the recipient, support network, and providers and are the basis for planning, developing, and implementing the Comprehensive Plan of Care (CPOC).

- Personal outcomes encompass the following:

  - Personal Goals

    Where and with whom the recipient lives and works, choice of companionship, satisfaction with service and personal life situations.

  - Self-Reliance

    Self-reliance is based on the recipient selecting his/her own daily activities to the extent possible. The recipient has the right to select social events or activities that would fit into their routine. They can take into consideration the time or place of these events, and their need for privacy. Sharing of intimate information should be the choice of the recipient.

  - Recipient Ambitions

    Interaction and participation with others in the community should be a part of the recipient's life to the degree desired. All persons perform different social functions and should be respected and have friends of their choice.

  - Personal Rights

    All recipients should be able to choose the services needed, realize progress, be treated fairly and be free from abuse and neglect. All recipients should be able to experience health, safety, and personal welfare to secure the best personal care and services.

- An outcome is based on the recipient's viewpoints, goals, and past experiences and

is intended to reinforce individuality.

- Individuals may have similar outcomes but it is unlikely that two people will express an outcome in the same way.

- Personal outcomes should be prioritized by the recipient and may change due to circumstances in the recipient's life.

- Personal outcomes are measurable.

- Personal outcomes are not:

  - Medical Outcomes—Medical outcomes focus on prevention, wellness and symptom reduction.

  - Functional Outcomes—Functional outcomes focus on increasing functional status in a designated area.

SUPPORT STRATEGIES

Case management seeks to develop support strategies by developing a network of informal community supports and when necessary paid formal supports to assist the recipient to achieve his/her desired personal outcomes.

- This support strategy should emphasize identifying, developing or maintaining natural/community supports based on the recipient's preferences and interests. This network may include family, friends, community populations, agencies or organizations, or any other community member(s).

- Whenever possible, strategies should include options for decreasing the recipients' reliance on formal, paid services, and promote cost effectiveness.

4.3 LEGAL BASIS OF CASE MANAGEMENT

4.3.1 MEDICAID

Case management has historically been viewed by Medicaid as an activity that assists in coordinating access to necessary services and care as appropriate to the needs of the individual. Aspects of case management have been an integral part of the Medicaid Program since its inception as an administrative function and also as a part of services furnished by certain providers

of medical care.

4.3.2 TARGETED CASE MANAGEMENT

In 1985, the Congress, recognizing the value and general utility of case management services, amended the Social Security Act and added a new section 1915(g) to allow states to furnish "optional targeted case management" to specific populations based on age, type or degree of disability, illness or condition, or any combination of characteristics. Under section 1915(g), case management services are defined as:

"Services which will assist individuals eligible under the State Medicaid Plan in gaining access to needed services, including medical, social, educational and other support services."

- The law also provides that:

  - There is no restriction on the recipient's freedom of choice of providers as required by Section 1902(a)(23) of the Social Security Act.

  - Medicaid payment is available only for case management services which assist Medicaid eligible recipients in gaining access to needed services and cannot be claimed as case management services for the cost of the actual services to which an individual is referred.

  - The Department of Health and Hospitals can restrict the number and enrollment of MR/DD providers. Only case management agencies having contracts with DHH will be allowed to serve MR/DD waiver recipients, Children's Choice waiver recipients and recipients of targeted EPSDT case management.

    Recipients in the MR/DD, Children's Choice waivers, and targeted EPSDT case management are limited to DHH contracted case management agencies. In a DHH region that has two (2) contractors, a contracted case management agency can not serve more than 60% of the total eligible recipients in their region. In a DHH region where there are three (3) contractors, a contracted case management agency can not serve more than 40% of the total eligible recipients in their region. When a contracted case management agency has met its capacity, any additional recipients that have selected this agency will automatically be assigned to the next available contracted case management agency. The automatic assignments will be made to the contracted case management agencies based on their RFP ranked scores.

- Payment for case management services is dictated by the attainment of outcomes as defined in the CPOC. The BHSF must ensure that payment for case management services does not duplicate payments:
  - For the same or similar services furnished by other programs, or
  - Under other Medicaid authority as an administrative function, or
  - As an integral part of a covered service.

- A technical amendment (Public Law 100-617) in 1988 specifies that the Medicaid Program is not required to pay for case management services that are furnished to recipients without charge.
  - This is in keeping with Medicaid's longstanding position as the payer of last resort, payments cannot be made for services for which no payment liability is incurred.
  - With the statutory exceptions of case management services included in Individualized Education Programs (IEP'S) or Individualized Family Service Plans (IFSP's) and services furnished through Title V public health agencies, payment for case management services cannot be made when another third party payer is liable.
  - Section 1915(c) of the Social Security Act allows states to develop services in the community for persons who would otherwise require institutional care. These services must be provided "pursuant to a written plan of care." Case management may be used as the mechanism to coordinate services.

NOTE: All recipients must sign a Freedom of Choice Form designating their choice of case management agency.

4.4 COMPONENTS OF CASE MANAGEMENT

4.4.1 THE PROCESS OF CASE MANAGEMENT

In practice, case management is an organized system by which the case manager assists the recipient to prioritize and define their desired personal outcomes, define appropriate supports and services, and access these supports and services.

- This is done through a process which consists of the following components:
  - Intake.
  - Assessment (Initial and Ongoing).
  - Development of a person centered Comprehensive Plan of Care (CPOC) or Individualized Family Service Plan (IFSP).
- Securing approval of the CPOC or IFSP - All targeted and waiver populations are subject to prior authorization requirements.
  - Review and approval of the CPOC by BCSS: (Mentally Retarded/Developmentally Disabled MR/DD and Children's Choice from the MR/DD waiver and Elderly and Disabled Adult waiver request for services registry.
  - Approval of the IFSP for non-waiver Infants and Toddlers is required through the establishment of eligibility for participation and referral form from the Department of Education Child Search Coordinator.
  - Approval of the CPOC for HIV recipients is required through the establishment of eligibility for participation.
  - Establishment of eligibility and approval of the CPOC for High Risk Pregnant Women (HRPW) is established through a referral from a licensed physician, licensed primary nurse associate or a certified mid-wife.
  - Approval of the CPOC for Nurse Home Visitation recipients is required through establishment of eligibility for participation.
  - Building/Implementing Supports.
  - Quarterly face to face home visits between the case manager and recipient as required by the waiver or target population criteria.
  - Monitoring Support Strategies (Monitoring of Service Providers).
  - Self-Evaluation.
  - Transition/Closure.

- Training of Staff.
- Collection of data in a database to be provided by DHH and provider will generate reports as requested.
- Internal case management agency Grievance Process.
- 24-hour toll-free phone line for recipients to access case managers. This must be a person not an answering machine.

- Effective case management is the connecting link between all services and should enhance the cost containment aspect of the continuum of services.

- The components of case management as well as the relevant policies and procedures are explained in detail in Section 5.

- For case management services provided as a waiver service, additional requirements apply. These are outlined in the **Waiver Services Provider Manual. See Louisiana Children's Choice Case Management and Direct Services Manaul and Elderly and Disabled Adult Waiver Manuals.**

4.4.2 TARGET AND WAIVER POPULATIONS

DHH case management services are targeted to specific populations and geographical areas determined to be the most likely to be in need of assistance in gaining access to necessary services from both Medicaid enrolled providers and other sources of service in the community. DHH has limited targeted and waiver case management services to the following specific populations and geographical areas in the state:

- Infants and toddlers with special needs;

- High-risk pregnant women from the following parishes, Orleans, Jefferson, St. Charles, St. John, and St. Tammany;

- Persons infected with HIV;

- Nurse Home Visitation for First Time Mothers who reside in the Department of Health and Hospitals (DHH) administrative regions of Thibodaux (Region 3), Lafayette (Region 4), Lake Charles (Region 5) and Monroe (Region 8);

- Early Periodic Screening Diagnosis and Treatment (EPSDT), medicaid eligible children (under age 21) who are on the Mental Retardation/Developmental Disabilities (MR/DD) waiver request for services registry;

- Persons in Waiver Program(s) who receive case management as a separate service.

NOTE: MR/DD, Children's Choice and EPSDT services are limited to contractors, including Children's Hospital (VACP) for ventilator dependant recipients.

All case management agencies must follow the policies and procedures included in this manual. Under DHH, Case Management has the same meaning as the term Family Service Coordination. Case management services must be delivered in accordance with all applicable federal and state laws and regulations.

4.5 ELIGIBILITY REQUIREMENTS FOR CASE MANAGEMENT FOR TARGET AND WAIVER POPULATIONS

Recipients of DHH case management services must meet the specific eligibility requirements applicable to the specific target or waiver populations. The geographical area residence requirement is applicable only to High Risk Pregnant Women and First Time Mothers. Recipients receiving Medicaid funded case management services must be Medicaid eligible in the months that services are provided. The provider is responsible for verifying eligibility prior to providing services. The eligibility requirements for each population are listed below.

4.5.1 HIGH RISK PREGNANT WOMEN

High Risk Pregnant Women case management is a set of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for the recipient rests with a specific qualified employee of the case management agency.

- The purpose of high risk case management services is to assist Medicaid eligible individuals in gaining access to needed Medicaid services to reduce low birth weight infants and infant mortality, to encourage the use of cost-effective medical care by referrals to appropriate providers, and to discourage over-utilization or duplication of costly services.

- High risk case management services must provide necessary coordination with providers of non-medical services such as nutrition, psycho-social or health education programs, when services provided by these entities are needed. The case manager must coordinate these services with needed medical services.

- The recipient must meet **ALL** of the following eligibility requirements for this target population in order to be enrolled in high risk pregnancy case management

services:

- Pregnant as verified by a licensed physician, licensed primary nurse associate, or certified nurse midwife.

- Determined high risk based on the completion of the "DHH Case Management Prenatal High Risk Screening Form", a medical risk screening and written referral from a licensed physician, licensed primary nurse associate, or a certified mid-wife.

- Must require services from both formal and informal multiple health, social service providers and is unable to access the necessary services.

4.5.2 HIV

The recipient must meet the following eligibility requirements for this target population in order to be enrolled in HIV infected case management services:

- Written verification of HIV infection by a licensed physician or laboratory test result is required.

AND

- The adult recipient must have reached, as documented by a physician, a level 70 on the Karnofsky scale (or cares for self but is unable to carry on normal activity or do active work), at some time during the course of HIV infection.

OR

The pediatric recipient (under 21 years of age) must display symptoms of illness related to HIV infection as documented by a licensed physician.

AND

- All recipients must require services from multiple formal or informal health or social service providers.

4.5.3 INFANTS AND TODDLERS WITH SPECIAL NEEDS

Infants and toddlers ages birth through two (2) years of age inclusive (0-36 months) must meet the following ChildNet Program eligibility criteria:

- A documented established medical condition determined by a licensed physician. In the case of a hearing impairment, a licensed audiologist or licensed physician must make the determination.

OR

- A developmental delay in one or more of the following areas:
  - Cognitive development
  - Physical development, including vision and hearing. Eligibility must be based on a documented diagnosis made by a licensed physician (vision) or a licensed physician or licensed audiologist (hearing)
  - Communication development
  - Social or emotional development
  - Adaptive development
- The determination of a developmental delay must be made by a multi-disciplinary evaluation team which includes the child's family and qualified professionals, as recognized by the Louisiana Department of Education. **The point of entry for all Infants and Toddlers is the written referral from the Department of Education's Child Search Coordinator.**

4.5.4 MENTALLY RETARDED/ DEVELOPMENTALLY DISABLED WAIVER (MR/DD)

Developmentally disabled children ages three (3) years and older and adults who are participants in the MR/DD Waiver. Case Management for this population, is a State Plan service, not a waiver service.

4.5.5 ELDERLY AND DISABLED ADULT WAIVER

Recipients, who qualify for admission to a nursing facility and are over age 65 or adults over age 21 and are disabled according to Medicaid standards, may receive Medicaid reimbursed case management as a waiver services under the Elderly and Disabled Adult Waiver. **These recipients must be approved for the waiver prior to case management services being reimbursed.**

4.5.6 NURSE HOME VISITATION FOR FIRST TIME MOTHERS

A Medicaid recipient must not be beyond the twenty-eighth week of pregnancy and must attest that she meets one of the following definitions of a first-time mother in order to receive Nurse Home Visit case management services:

- Is expecting her first live birth, has never parented a child, and plans on parenting this child, or
- Is expecting her first live birth, has never parented a child and is contemplating placing the child for adoption, or
- Has previously been pregnant, but has not delivered a child because of an abortion or miscarriage, or
- Is expecting her first live birth, but has parented stepchildren or younger siblings, or
- Had previously delivered a child, but her parental rights were legally terminated within the first six months of that child's life, or
- Has delivered a child, but the child died within the first six months of life.

A physician's statement, medical records, legal documents, or birth and death certificates will be required as a verification of first time mother status.

4.5.7 CHILDREN'S CHOICE

Services under the Louisiana Children's Choice are available only to individuals who meet all the following criteria. The child must continue to meet all waiver eligibility criteria to remain eligible.

- Age

  The age range is birth through 18 years of age for those children entering the Louisiana Children's Choice. Children will be transferred to another appropriate MR/DD waiver when they reach age 19 if they continue to meet all waiver eligibility criteria.

- Slot Availability

  The child's name must be on the statewide MR/DD Waiver request for services registry. Names on the request for services registry will be selected in date/time order of the earliest request for services for children of appropriate age. If the family chooses to have the child receive services under Louisiana Children's Choice, the child's name will be removed from the statewide MR/DD Waiver request for services registry.

- Living Arrangement

  The child must live with his/her natural or adoptive families, step-families or other relatives, legal guardians or with foster families, or choose to leave an institution to return home to his/her families.

- Financial Eligibility

  Financial eligibility must be determined for all applicants by the BHSF Medicaid eligibility office. The following eligibility criteria must be met:

  - INCOME - must be less than three times the Supplemental Security Income (SSI) amount for the child (excluding consideration of parental income beginning the month after the month of entry into the Louisiana Children's Choice); and

  - RESOURCES - less than the SSI resource limit of $2,000 for a child (excluding consideration of parental resources beginning the month after the month of entry into the Louisiana Children's Choice); and

  - DISABILITY - meets Social Security Administration (SSA) definition of disability; and

  - AGE - birth to 18 years of age; and

  - CITIZENSHIP - U.S. citizen or qualified alien; and

  - RESIDENCY - resides in Louisiana; and

  - ENUMERATION - has or will apply for Social Security number; and

  - CONTINUITY OF STAY - has received a waiver service thirty (30) days

or more.

Each applicant must meet a separate categorical requirement of disability as defined by the Social Security Administration. If the applicant does not receive SSI, a disability determination is required as part of the eligibility process. The case manager will submit medical information to BHSF. The disability determination is made by the BHSF Medical Eligibility Determination Team and is separate from the medical certification/level of care determination made by BCSS for waiver service eligibility.

4.5.8 EPSDT TARGETED POPULATION

Medicaid recipients between the ages of 0 and twenty one (21) years old inclusive, (eligibility for case management services ends on the recipients 21st birthday) who are on the MR/DD waiver request for services registry and meet the specified eligibility criteria as follows:

- Placement on the MR/DD waiver request for services registry on or after October 20, 1997, and have passed the OCDD Diagnosis and Evaluation (D&E) process by the later of: October 20, 1997 or the date they were placed on the MR/DD waiver request for services registry;

  OR

- Placement on the MR/DD waiver request for services registry on or after October 20, 1997, but who did not have a D&E by the later of: October 20, 1997, or the date they were placed on the MR/DD waiver request for services registry. Those in this group who subsequently pass or passed the D&E process are eligible for these targeted case management services. For those who do not pass the D&E process, or who are not undergoing a D&E, they may still receive case management services if they meet the definition of a person with special needs.

  Special needs is defined as a documented, established medical condition, as determined by a licensed physician, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational, and other services. In the case of hearing impairment, the determination of special needs must be made by a licensed audiologist or physician.

- Documentation that substantiates that the EPSDT recipient meets the definition of special needs for case management services include but is not limited to:

  - Receipt of special education services through the state or local education agency;

- Receipt of specialized regular medical services from one or more physicians;

- Receipt of or application for financial assistance such as SSI because of a medical condition, or the unemployment of the parent due to the need to provide specialized care for the child;

- A report by the recipient's physician of multiple health or family issues that impact the recipient's ongoing care;

OR

- A documentation of developmental delay based upon the Parent's Evaluation of Pediatric Status, the Brignance Screens, Child Development Inventories, Denver Developmental Assessment, or any other nationally recognized diagnostic tool.

References to the Philosophy of Case Management is taken from the Council on Quality Leadership in Support of People with Disabilities publication **Personal Outcome Measures, 1997.**

SECTION 5
COVERED SERVICES
AND
PROVIDER RESPONSIBILITIES

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5.0 INTRODUCTION

There are three (3) waiver populations served by case management providers. Included in this group are: MR/DD, Louisiana Children's Choice and Elderly and Disabled Adults. There are five target populations served by case management providers. Included in this group are: EPSDT, Infant and Toddler, Nurse Home Visits for First Time Mothers, HIV and High Risk Pregnant Women.

The current case management populations under contract are the MR/DD waiver recipients, Louisiana Children's Choice waiver recipients and the EPSDT Targeted population. Case Management services for Louisiana's Children's Choice recipients are described in detail in the Louisiana Children's Choice Case Management Manual and Direct Service Provider Manual.

The case management provider is responsible as the first step in the intake process to determine that the recipient is Medicaid eligible. The second step requires a determination that the eligible Medicaid recipient is also eligible for case management services. This provider must be familiar with the Unisys REVS, MEVS and Swipe Cards as a means of verifying recipient eligibility. The case manager is responsible to access these files to verify that the recipient is Medicaid and/or waiver eligible. Documentation of eligibility must be filed in the recipient's case record.

Following the intake and assessment process, the case manager develops the Comprehensive Plan of Care (CPOC). The CPOC format utilized is specific to the waiver or target population. (See Appendix B). CPOC's must be person centered, recipient focused and must include natural supports that the recipient can access or provide in addition to an assessment of what public supports are necessary to provide an adequate environment for the recipient. References to the philosophy of case management is taken from the Council on Quality Leadership in Support of People with Disabilities publication **Personal Outcome Measures, 1997.** Documentation of assessment and service planning must be filed in recipient's case record.

Certain waiver populations require follow-up monitoring of services and support strategies. For all waiver and target populations, transition or closure of case management services must occur in response to the recipient's request or if the recipient is no longer eligible for services. The closure process must ease the recipient's transition to other services or care systems.

Specific requirements for waiver or target populations are discussed below.

5.1 MR/DD WAIVER

5.1.1 ELIGIBILITY

Developmentally disabled children age three (3) years and older and adults must be a participant in the MR/DD Waiver. Case Management is a mandatory service for those individuals in the waiver.

5.1.2 INTAKE

Intake is the entry point into case management. Intake determines the recipient's eligibility, need, appropriateness, and request for case management and waiver services as an alternative to institutionalization.

Required Intake Procedures

These case management intake procedures are applicable for the MR/DD waiver population. Referrals for case management services are from the Bureau of Community Supports and Services (BCSS) or designee. The required procedures of intake screening are as follows:

- Interview the recipient within three (3) working days of receipt of the Freedom of Choice(FOC) form, preferably face-to-face in the home and obtain required DHH demographic information.

- Determine if the recipient is eligible for services as indicated by medical and/or other applicable eligibility requirements of the MR/DD target population. If the recipient is not Medicaid eligible, the contractor will not be paid. Historically, one percent fall into this category. Medicaid will not reimburse for any referrals or assistance in the application process. The initial intake process is as follows:

  - Determine the recipient's level of need.

  - Determine the need for immediate case management intervention.

- Inform the recipient/family of procedural safeguards, rights and grievance procedures which include the following:

  - Determine if the recipient accepts case management and the requirements of face-to-face home visits no less than quarterly or more often as

required by recipient's needs and desired outcomes.

- Advise the recipient of their right to change case management providers and case managers, the availability of services and case management as an alternative to institutionalization.

- The recipient must sign a standardized intake form to verify the above procedural safeguards.

- Availability of the BCSS toll free 1-800-660-0448 Helpline.

- Case management is **not** a MR/DD waiver service and is not considered as part of the 30-day continuity of stay requirement.

- Determine whether the recipient is receiving case management from another provider. If so, follow the procedures for changing providers described in this section.

- Obtain signed release of information form(s) from the recipient/family.

- If the recipient does not meet eligibility for case management and/or MR/DD waiver services, notify the recipient and the BCSS Regional Office immediately, inform the recipient of their appeal rights and direct the recipient to other service options, or to the source of the initial referral.

5.1.3 ASSESSMENT

Assessment is defined as the process of compiling and integrating formal/professional and informal information relevant to the development of a person centered CPOC which is based on, and responsive to the recipient's desired personal outcomes, functional status, and current service needs. The assessment provides the foundation for case management by defining the recipient's needs and assisting in the development of the mandatory CPOC.

OCS/OYD/OCDD Assessments

Assessments performed on children in the custody of the Office of Community Services (OCS) or Office of Youth Development (OYD) who are being considered for an MR/DD waiver slot must:

- Involve the assigned foster care worker or probation officer; and,

- Be approved by the agency with legal custody of the child.

Assessments performed on recipients in the custody of the Office of Citizens with Developmental Disabilities (OCDD) must involve the assigned Regional OCDD office staff and must be approved by OCDD.

Required Ongoing Assessment Procedures

The assessment process is ongoing and must reflect changes in the recipient's life, individual needs, and changing personal outcomes. These changes include strengths, needs, preferences, abilities, and resources. If there are significant changes in the status of the recipient or his/her prioritized needs, the case manager must revise the CPOC.

Time Frames for Assessment

- The initial assessment must begin within seven (7) calendar days of the referral/linkage and be completed within 30 calendar days of the referral/linkage.

- A reassessment may be conducted at any time, particularly with a significant change, but must be completed within seven (7) calendar days of notice of a change in the recipient's status.

- Quarterly (typically every 90 days from the date of the CPOC), in the home, the case manager and the recipient shall review the CPOC to determine if the recipient's needs continue to be addressed.

- Annually

- MR/DD waiver re-certifications - The total packet must be completed and submitted to the BCSS Regional Office no later than thirty-five (35) calendar days but as early as sixty (60) calendar days prior to expiration of the CPOC. Incomplete packets will not be accepted. Case managers will be responsible for retrieving incomplete packets from the regional office. Sanctions may be applied and/or payment withheld to agencies that:

  - Submit late CPOCs:
  - CPOCs that do not have appropriate documentation and/or
  - CPOCs outside of Medicaid case management and MR/DD waiver rules

and regulations.

Assessment Process

The person-centered supports assessment must be conducted by the case manager and consists of the following:

- Face-to-face home interviews with the recipient;
- Direct observation of the recipient;
- Direct contact with family and other natural supports;
- Discussion with other professionals and support/service providers as indicated by the situation and the desires of the recipient;
- Discussion of Freedom of Choice and the availability of all services, and
- Discussion of what the individual requires from case management.

Characteristics And Components of The Assessment

- A standardized instrument for certain targeted populations;
- Identifying information;
- The personal outcomes envisioned, defined and prioritized by the recipient;
- Medical/physical;
- Psycho social/behavioral information and documentation;
- Developmental/intellectual information and documentation;
- Socialization/recreational information and documentation, including relationships that are important to the recipient and the social environment of the recipient;
- The patterns of the recipient's everyday life;
- Identification of natural supports;
- Information and documentation on financial resources;
- Educational/vocational information and documentation;
- Information on the current status of housing and the physical environment;
- Information about previously successful and unsuccessful strategies to achieve the recipient's desired personal outcomes;
- Any other information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes. Such information may include input from formal and informal service providers and care givers as relevant to the personal outcomes; and
- Identifies areas where a professional evaluation is necessary to determine appropriate services or interventions.

5.1.4 RESPONSIBILITIES OF THE CASE MANAGER

The case manager is responsible for compiling and integrating formal/professional and informal information relevant to the development of an individualized CPOC. The case manager must:

- Assist in arranging professional/clinical evaluations and other components of the assessment to develop strategies for obtaining the services, resources and supports needed to achieve the recipient's personal outcomes.

  *Note: **Evaluations, tests, or reports are NOT covered case management activities. The necessary medical, psychological, psycho social or other clinical evaluations, tests, etc. may be covered by Medicaid or other funding sources.***

- Identify, compile and review the array of formal assessments and other documents that are relevant to the recipient's needs, interests, strengths, preferences and desired personal outcomes.

- Obtain the recipient's authorization to secure appropriate services. In addition, a signed release of information must be obtained and a copy filed in the case record.

- Prepare the annual social summary.

- Report and document any incident/complaint/abuse to BCSS.
  Note: See Appendix D

- Provide any other requirements necessary for the recipients of the MR/DD waiver.

5.1.5 COMPREHENSIVE PLAN OF CARE

CPOC planning refers to a process whereby an analysis of information from the formal evaluations and the person-centered supports assessment is utilized. The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the recipient.

- The CPOC is developed through a collaborative process involving the recipient,

family, friends or other support systems, the case manager and appropriate professionals/service providers and others who know the recipient best.

- The CPOC establishes direction for all persons involved in providing supports and services for the recipient, describing how the needed supports and services interact to form overall strategies that assist the recipient to maintain or achieve the desired personal outcomes.

- A CPOC ensures that the paid medical services and other resources are medically necessary and meet the recipient's health and welfare needs as determined by the assessment. These services and resources are documented in the approved CPOC and are to be provided in a cost-effective manner.

- Current service providers must be involved in the development of the CPOC. The direct service provider's participation should relate to their ability to provide the requested service, not determine what services are needed.

- The CPOC represents a strategy for ensuring that services are appropriate, available, and responsive to the recipient's changing goals and needs are updated by the assessment. The case manager should include the recipient's response/satisfaction to services previously received.

- The CPOC should not be considered a treatment plan. A treatment plan contains the specific clinical interventions which service providers prepare and use to achieve treatment or rehabilitation goals. The CPOC should be considered a "master plan". This plan consists of a comprehensive summary of information to aid the recipient to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining their individual needs and desired personal outcomes.

Required CPOC Procedures

The CPOC meeting must be a face-to-face home visit with the recipient and members of his/her support network, which may include family members, and must include service providers, if already identified, appropriate professionals, and others who are well acquainted with the recipient. This meeting must be held at a time that is convenient for the recipient.

The CPOC must be outcome oriented, individualized and time limited. Essential elements of the planning process include:

- Tailoring the CPOC to the recipient's needs based on the on-going person centered assessment.

- Developing mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services.

- Assisting the recipient to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes which involves assisting them to identify specific, realistic needs and choices for the CPOC.

- Assisting the recipient in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes, including action steps, review dates and individuals who will be responsible for specific steps.

- The CPOC must incorporate steps which empower and help the recipient to develop independence, growth, and self management.

- The CPOC must not be completed prior to the CPOC meeting.

- The annual CPOC is not a substitute for the quarterly review. Material and information developed as part of the quarterly review should be used to plan.

- The recipient, case manager, members of the family/natural support system, direct service providers, and appropriate professional personnel must be directly involved in the development of the CPOC.

- The CPOC must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the recipient must be clearly explained.

- Signatures of all participants are required.

- BCSS must approve the CPOC before issuing PAs and the initiation of services. No service will be prior authorized or delivered until all eligibility is met.

Required CPOC Components

The CPOC must incorporate the following required components:

- The recipient's prioritized personal outcomes and specific strategies to achieve

or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed paid formal services;

- Budget payment mechanism, as applicable;
- Target/resolution dates for the achievement/maintenance of personal outcomes;
- The CPOC must include the frequency and location of the case managers face-to-face contacts with the recipient, service providers, and others in the support network.
- Assigned responsibilities:
  - Identifying the preferred formal and informal service providers and specifying the service arrangements.
  - Identifying individuals who will assist the case manager in planning, building/implementing supports, or direct services.
  - Provide information to the recipient regarding appropriate Medicaid services.
  - Assist in planning for flexibility in frequency, intensity, location, time and method of each service or intervention, and plan cost is documented and consistent with the CPOC and recipient's desired outcomes.
  - Obtain Freedom of Choice (FOC) form with the names of local providers enrolled in Medicaid.
  - Changes in waiver service provider(s) can only be requested by the recipient; any request for a change requires a completion of a FOC form.
  - All participants present at the CPOC meeting must sign the CPOC. The CPOC must contain a signature of the recipient or responsible party indicating their agreement with the CPOC.

Note: ***BCSS Regional Office staff responsible for review and approval of CPOCs will not consider a plan for approval unless there is a signature by the recipient or responsible party indicating their agreement with the CPOC. Without a signature there is no documentation that the ID***

team reached a consensus regarding the services described on the plan.

Note: ***Plans of care and/or services will not be prior authorized and/or delivered until all eligibility is met.***

- The CPOC must be completed and approved as per CPOC instructions (Appendix B).

- The recipient must be informed of his or her right to refuse a CPOC after carefully reviewing it and the process for complaint resolution.

Note: ***MR/DD14's (Authorization for services) will not begin prior to the CPOC approval date.***

Note: ***After the initial CPOC is completed, all billable ongoing case management services must be provided according to the current approved CPOC.***

Required CPOC Time Frames

The completed CPOC and financial eligibility documents must be completed and received by BCSS Regional Office within thirty-five (35) calendar days from the date of the linkage by BCSS or designee. All incomplete packets will be returned.

- The CPOC must be revised annually or as necessary to meet the needs of the recipient and must be reflected in the approved revised CPOC and submitted to the BCSS Regional Office no later than 35 calendar days prior to expiration.

- The CPOC must be reviewed at least quarterly to ensure that the personal outcomes and support strategies are consistent with the needs and desires of the recipient.

- Routine changes must be submitted fifteen (15) working days prior to the change (vacations, family schedules, and school out of session).

- Emergency changes must be submitted within twenty-four(24) hours or the next working day

Changes in the CPOC

- If there are significant changes in the way the recipient defines or prioritizes the personal outcomes, and/or if there are significant changes in the support strategies or service providers, the case manager must revise the CPOC to reflect these changes. The revisions to the CPOC must identify the recipient's new service needs, outline goals/needed supports and targeted outcome for the recipient based on the IDT meeting. A BCSS revision change form, BCSS-11R must be submitted to the BCSS Regional Office for approval for all MR/DD waiver recipients.

- Upon receipt of the approved BCSS 11R authorizing service(s) changes, the BCSS Regional office will issue a new MR/DD 14 to the case management agency per BCSS BLAST schedule.

  Note: The annual date of the CPOC never changes.

5.1.6 BUILDING AND IMPLEMENTING SUPPORTS

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

Responsibilities of The Case Manager

The case manager is responsible for assisting to build and implement the supports and services as described in the approved CPOC. The case manager is responsible for:

- Assisting the recipient to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the approved CPOC.

- Being knowledgeable of potential community resources, including formal resources (Food Stamps, SSI, housing, etc.)

- Being knowledgeable of all Medicaid services and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.

- Communicating, as often as necessary, coordinating and problem solving with

support and service providers.

- Providing to all service providers within 3 days all MR/DD 14's received from BCSS or designee.

- A comprehensive review of the current approved CPOC must be completed at a minimum of every quarter to ensure that the personal outcomes and support strategies contained in the CPOC are consistent with the needs of the recipient.

- The case manager must notify the direct service provider(s) regarding the time and place of the quarterly review and encourage their participation.

- Assisting the recipient to initiate, develop and maintain a natural support network and to obtain the services identified in the approved CPOC assuring that they meet the recipient's individual needs.

- Training and supporting the recipient to become an independent self advocate to select providers and utilize community resources to achieve and maintain his/her desired outcomes.

- Advocate on behalf of the recipient to help establish, expand, maintain and strengthen the natural support network, and obtain appropriate services. This may involve calling and/or visiting recipients, community groups, organizations or agencies with or on behalf of the recipient.

- Requesting services compliant with all Medicaid rules and regulations.

- Oversight of the service providers to ensure that the recipient receives appropriate services and outcomes as designated in the approved CPOC. CPOC approval must be received prior to initiating and delivery of services. No service will be prior authorized or delivered until all eligibility is met. The PA for direct service providers will begin on the date BCSS issues the 51-NH.

- Providing a copy of the approved CPOC and any subsequent revisions for the home record book and all direct waiver service providers for their files.

- Assuring a copy of the approved CPOC is made available to all staff directly involved with the recipient.

- Assisting the recipient to overcome obstacles, recognizing potential

opportunities, and developing creative opportunities.

- Meeting with the recipient in a face-to-face home visit, at least once per quarter or more often if necessary to meet the individual's needs. This should be documented in the CPOC.

- When preparing quarterly summary, case manager must indicate the dates of services being reviewed and commented on. (Actual time period being reviewed (ex. April 27, 2002 to July 27, 2002)

Note: ***Advocacy is defined as assuring that the recipient receives appropriate services of high quality and locating additional services not readily available in the community.***

Note: ***After the initial CPOC is completed, all billable ongoing case management services must be provided according to the current approved CPOC.***

5.1.7 MONITORING SUPPORT STRATEGIES

The case manager and the recipient develop an action plan to monitor and evaluate strategies to ensure continued progress toward the recipient's personal outcomes.

Procedures For Monitoring Support Strategies

The case manager must contact the recipient within ten (10) working days after the initial CPOC is approved and after services begin to assure the appropriateness and adequacy of the service delivery.

- Monitor the service provider(s) no less than quarterly. This ongoing monitoring assesses the effectiveness of the support strategies and identifies changes in the recipient's needs or other health and welfare concerns. All components should be monitored and the frequency and intensity must be adjusted to meet the needs of the recipient. Records must be kept of all monitoring in a separate file. The components of the required monitoring are as follows:

  - Monitoring at the formal service provider's place of business

    - Review of the Remittance Advice (RA) is required only if the services are not provided. Copies of the RA are required only if

there is a discrepancy. Any discrepancy of improper billing shall be reported to BCSS Regional Office.

- Review and obtain copies of the progress notes from the service provider's case records to ensure they reflect the services provided. The progress notes must describe the recipient's progress toward goals and must be maintained in the recipient's case record.

- Progress notes must reflect any meetings with service providers and the content of the discussion regarding working toward or obtaining the recipient's personal outcomes.

- Review deficiencies found in previous reviews conducted by the case management agency or BCSS Monitoring Unit to ensure corrective action has been taken. If corrective action has not been taken or is inadequate, the case management agency must notify BCSS Regional office.

- Observation of Services

  The case manager must observe the services delivered by the formal direct service provider. This monitoring may be incorporated into the required quarterly home visit if the service provider is present and the service is routinely delivered in the home. Services must be monitored where they are delivered.

  - Review of the service provider's current log. Check to see if it is correct and current. Make note of where it is kept. The log may contain such items as:

    - Progress notes
    - Time sheets
    - Medication administration forms
    - Delegation forms
    - Emergency evacuation plans, and
    - Emergency phone numbers

  - Does the recipient feel he/she is meeting his/her outcome? Are the times convenient and satisfactory to the recipient?

- Are the services provided adequate and of quality?
- Are the providers present at the times indicated?
- Review service provider plan of care to ensure all approved CPOC revisions are incorporated.

- Attend meetings with educational, residential and other service providers
  - The case manager shall have progress notes that reflect the discussion in these meetings and the progress towards the outcomes.
  - Make unscheduled home visits to verify service provider is actually in the home per the schedule on the approved CPOC.
- Telephone call
  - The case manager must do periodic telephone monitoring to verify the service provider is in the home and a log should be maintained in the recipient's case record. Include recipient name, provider name, time, date and activity. Deficiencies found shall be noted in the monitoring file.
- Inform the recipient as to the necessity to contact the case manager of significant changes in his/her status or if problems arise with his/her service providers. A major change in status requires a reassessment.
- Inform recipient of the BCSS toll free 1-800-660-0488 Helpline.
- Notify service providers within 3 working days of written changes in the approved CPOC.
- Monitor waiver providers for compliance with waiver standards and report non-compliance to the BCSS Regional Office.
- Meet with the recipient in his/her home quarterly or more frequently if necessary to evaluate effectiveness of the support strategies and if necessary, the revision of the CPOC. (In home requirement waived on written request only by parents.)

*Note: **BCSS Regional office must be notified of any requests made by the parents for the home visit waiver.***

- Document the quarterly visits in the case record using quarterly progress notes. Other contacts and follow up which occur more frequently can be documented in the case notes and do not require the use of quarterly progress notes. Progress notes may be brief as long as all required components are addressed. Information documented in the progress notes do not need to be duplicated in the case record.

- Quarterly progress notes must address personal outcomes separately and reflect the recipient's interpretation of the outcomes. The quarterly progress notes must address at least the following issues:

  - Desired personal outcomes
  - Strategies to achieve the outcomes
  - Effectiveness of the strategies
  - Obstacles to achieving the desired outcomes
  - New opportunities
  - Developing a new action plan

*Note: **All contacts shall be entered no less than monthly into CMIS. No billing for the month shall occur until all contacts have been entered into CMIS.***

5.1.8 CASE MANAGEMENT TRANSITION/CLOSURE

The transition or closure of case management services for recipients in the MR/DD waiver must occur in response to the request of the recipient, or if the recipient is no longer eligible for services as described below. The closure process must ease the transition to other services or care systems.

Closure Criteria

Case management services closure criteria include but are not limited to the following:

- The recipient requests termination of services.
- Death of the recipient.
- Permanent relocation of the recipient out of the service area.

- Long term admission to a hospital, institution or nursing facility.
- Does not meet the criteria for MR/DD waiver case management established by the funding source (Medicaid).
- The recipient requires a level of care beyond that which can safely be provided through case management.
- The safety of the case manager is in question. The case management agency must contact BCSS Regional office to discuss the situation.
- 30-day Continuity of Stay - if the individual does not receive a waiver service within 30 consecutive days, they are ineligible for services. Case management is not a MR/DD waiver service. There are exceptions such as hospitalization.
- If an individual is institutionalized, the case manager must contact the BCSS Regional office to discuss the situation. The case manager must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services.
- Recipient refuses to comply with case management and BCSS requirements.
- The case management agency closes (see transfer procedures).
- The recipient no longer meets all eligibility requirements for MR/DD waiver participation.
- The recipient is discharged from waiver.

Note: ***If the recipient refuses to comply with case management requirements or the recipient does not receive any waiver services as required by the 30 day continuity of stay, the case manager must document all instances appropriately and contact BCSS Regional Office immediately.***

Required Transition/Closure Procedures

- Transition/closure decisions should be reached with the full participation of the recipient. If a recipient becomes ineligible for services, the case manager must notify the recipient and BCSS Regional office immediately.

Note: ***If the recipient's case is closed as a result of non compliance with Medicaid and waiver requirements, a note must be made to the record regarding the recipient's response to the case closure.***

- The case manager must complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient methods of negotiating their own service needs.

- The case management agency must notify the BCSS of the transition/closure

four weeks prior to the closure to allow BCSS to establish a transition plan. Send the closure notice to the following address:

DHH Bureau of Community Supports and Services
Case Management Program Administrator
446 North 12th Street
Baton Rouge, Louisiana 70802- 4613

- The agency must follow their own policies and procedures regarding intake and closure.

- A case closure/transfer discharge summary must be prepared by the case manager within 14 calendar days of discharge and submitted to the BCSS Regional office.

- The case manager must assure that the receiving agency, program or case manager receives copies of the most current approved CPOC, any revisions to the CPOC and related documents such as:

  - Forms - 142, 18 LTC, 51NH,
  - Most current 6 months of progress notes,
  - Social evaluations and any updates,
  - Psychological evaluation and any updates,
  - Most current 90-L,
  - Current MR/DD 14's,
  - Any environmental modifications/assistive devices and any documentation on usage of lifetime limits,
  - Revisions to a prior CPOC,
  - CMIS Complexity Scale,
  - Physician delegation forms for current CPOC,
  - Home health plans,
  - Service provider plans of care, and
  - Any psychiatric notes.

(The 148 must be completed to reflect the date of the transfer of records and submitted to the BCSS Regional office, BCSS or designee for linkage and local parish Medicaid office.)

- The case manager must notify all service providers, including the personal emergency response system provider listed on the approved CPOC when

recipient's case is closed or transferred.

- The case manager must provide assistance to the recipient and to the receiving agency, program or case manager to assure a smooth transition.
- The case management agency must serve as a resource in coordinating of services to the recipients who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities.

Note: All closures must be entered into CMIS immediately.

5.1.9 PROCEDURES FOR CHANGING CASE MANAGEMENT AGENCIES

General Procedures For MR/DD Waiver Case Managers

A recipient may change case management agencies once after a six month period and for "Good Cause" provided that the new agency has not met the maximum number of recipients allowed. "Good Cause" is defined as:

- The recipient moves to a different DHH region;

- The recipient and case management agency have unresolved difficulties and mutually agree to a transfer. This transfer must be approved by the BCSS Case Management Program Administrator.

- The MR/DD waiver population must be prior authorized for case management services, see the procedures for prior authorization in Section 7.

- Once the recipient has selected a new case management provider and has been linked, the new provider must complete the FOC file transfer form.

- Upon receipt of the completed form, the transferring case management agency must provide copies of the following information:

  - Most current approved CPOC and any subsequent revisions,
  - Current assessments on which CPOC is based,
  - Number, type and units of services used in the calendar year,
  - Current and previous quarter's progress notes,
  - PA and Form MR/DD-14 (For MR/DD waiver participants),

- Forms - 142, 18 LTC, 51NH,
- Most current 6 months of progress notes,
- Social evaluations,
- Psychological evaluation,
- Most current 90-L,
- Current MR/DD 14's,
- Any environmental modifications/Assistive devices and any documentation on usage of lifetime limits,
- CMIS Complexity Scale,
- Physician delegation forms for current CPOC,
- Home health plans,
- Service provider plans of care, and
- Psychiatric notes.

(The 148 must be completed to reflect the date of the transfer of records and submitted to the BCSS Regional office, BCSS or designee for linkage and the local parish Medicaid office.)

- The new case management agency must bear the cost of copying which cannot exceed the community's competitive copying rate. If the information is not received by the new case management agency in a timely fashion, or if the information is incomplete, the appropriate BCSS Regional office should be contacted for assistance.

- The transferring case management agency shall provide services up to the transfer of records and may bill for services after dated notification is received (transfer of records) by the receiving case management agency. In the month the transfer occurs, the receiving case management agency shall begin services within three working days after the transfer of records and may bill for services the first full month after the transfer of records. The receiving case management agency must submit the required documentation to BCSS or designee to begin prior authorization immediately after the transfer of records.

5.2 LOUISIANA CHILDREN'S CHOICE WAIVER

For information on the requirements for the components of case management of Louisiana Children's Choice waiver recipients see Section 5 of the Louisiana Children's Choice Case Management Manual and Direct Service Provider Manual.

Case management services for Louisiana Children's Choice recipients are described on page 5-3 of the Louisiana Children's Choice Case Management Manual.

The following components of case management for Louisiana Children's Choice recipients can be found in the Louisiana Children's Choice Case Management Manual as described below:

- Intake procedures are described on page 5-6,
- Assessment for case managers is described on page 5-7,
- Responsibilities of the case manager are described on page 5-9,
- Comprehensive Plan of Care requirements are described on page 5-10,
- Building and Implementing Supports are described on page 5-15,
- Monitoring Support Strategies are described on page 5-16,
- Case Management Transition and Closure are described on page 5-22, and
- Procedures for changing case management providers are described on page 5-23.

Note: ***No service for recipients of the Louisiana Children's Choice waiver will be prior authorized or delivered until all eligibility is met. The PA for direct service providers will begin on the date BCSS issues the 51-NH.***

5.3 ELDERLY AND DISABLED ADULT WAIVER

5.3.1 ELIGIBILITY

The Elderly and Disabled Adult Waiver (EDA) is a Medicaid Home and Community-Based Services Waiver providing alternative services to individuals which allows them to live in the least restrictive environment or most appropriate setting in the community instead of a nursing facility or institution.

The EDA serves individuals age 65 or older, and age 21 years or older who are disabled according to Medicaid standards, whose onset of disability was after the age of 21. Individuals requesting services must meet the admission requirements for nursing facility level of care criteria (both medical and financial).

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA).

5.3.2 INTAKE

Intake is the entry point into case management. The purpose of the intake process is to evaluate the applicants request for services and to determine the eligibility status for waiver services in the least restrictive setting as an alternative to nursing facility/institutional care.

REQUIRED INTAKE PROCEDURES

The case manager is responsible for completing the required intake procedures for the Elderly and Disabled Adult waiver. Referrals for case management services are from the BCSS or designee. The applicant is offered a freedom of choice form(FOC) for case management and is linked by the BCSS or designee to the case management agency. The case manager is required to follow the procedures of intake screening as follows:

- The BCSS or designee notifies the case management agency of the applicant's choice, the case manager makes the initial contact.
- Contact the applicant within three (3) working days of the receipt of the FOC form, and a face-to-face interview in seven (7) days in the applicant's home to begin the intake assessment.
- Determine the applicant's need for case management and that they accept case

management. Case management is a mandatory service in the Elderly and Disabled Adult waiver.

- Initiate the development and implementation of person centered planing and the Comprehensive Plan of Care (CPOC) process.

- Provide copies of the rights and responsibilities, notice of the BCSS toll free 1-800-660-0488 Helpline, grievance procedures and appeal rights to the applicant/family.

- Advise the applicant of their right to change case management provider or case manager, and that waiver services and case management services by the waiver program are alternatives to institutional placement. Signed documentation that the applicant has been provided informed choice of home and community based services or institutional placement and must be placed in the applicant's record.

- Determine if the applicant is already receiving case management services or other services from other providers. If so, follow the procedures for changing providers described in this chapter.

- Obtain signed release of information form(s) from the applicant.

- If the Elderly and Disabled Adult waiver supports and services are not appropriate to meet the applicant's needs or if the applicant does not meet eligibility for waiver services, (medical or financial) notify the applicant and BCSS Regional office immediately and direct the applicant to other service options, or alternatives.

Note: ***Intake activities performed solely to determine eligibility and need for Elderly and Disabled Adult targeted case management are not billable to Medicaid.***

5.3.3 ASSESSMENT

Assessment is defined as the process of compiling and integrating formal/professional and informal information relevant to the development of a person centered CPOC which is based on, and responsive to the recipient's desired personal outcomes, functional status, and current service needs. The assessment provides the foundation for case management by defining the recipient's needs and assisting in the development of the mandatory or required CPOC.

Required Ongoing Assessment Procedures

The assessment process is ongoing and must reflect changes in the recipient's life, his/her individual needs, and changing personal outcomes. These changes include strengths, needs, preferences, abilities, and resources. If there are significant changes in the status of the recipient or their prioritized needs, the case manager must revise the CPOC.

Time Frames for Assessment

- The initial assessment must begin within seven (7) calendar days of the referral/linkage and be completed within 30 calendar days of the referral/linkage.

- A reassessment may be conducted at any time, particularly with a significant change, but must be completed within seven (7) calendar days of notice of a change in the recipient's status.

- Quarterly (typically every 90 days from the date of the CPOC), in the home, the case manager and the recipient shall review the CPOC to determine if the recipient's needs continue to be addressed.

- Annually

- EDA waiver re-certifications - The total packet must be completed and submitted to the BCSS Regional Office no later than thirty-five (35) calendar days but as early as sixty (60) calendar days prior to expiration of the CPOC. Incomplete packets will not be accepted. Case managers will be responsible for retrieving incomplete packets from the regional office. Sanctions may be applied and/or payment withheld to agencies that:

  - Submit late CPOCs:
  - CPOCs that do not have appropriate documentation and/or
  - CPOCs outside of Medicaid case management and EDA waiver rules and regulations.

Assessment Process

The person-centered supports assessment must be conducted by the case manager and consists of the following:

- Face-to-face home interviews with the recipient;
- Direct observation of the recipient;
- Direct contact with family and other natural supports;
- Discussion with other professionals and support/service providers as indicated by the situation and the desires of the recipient;
- Discussion of Freedom of Choice and the availability of all services, and
- Discussion of what the recipient requires from case management.

Characteristics and Components of the Assessment

- A standardized instrument for the Elderly and Disabled Adult population;
- Identifying information;
- The personal outcomes envisioned, defined and prioritized by the recipient;
- Medical/physical;
- Psycho social/behavioral information and documentation;
- Developmental/intellectual information and documentation;
- Socialization/recreational information and documentation, including relationships that are important to the recipient and the social environment of the recipient;
- The patterns of the recipient's everyday life;
- Identification of natural supports;
- Information and documentation on financial resources;
- Educational/vocational information and documentation;
- Information on the current status of housing and the physical environment;
- Information about previously successful and unsuccessful strategies to achieve the recipient's desired personal outcomes;
- Any other information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes. Such information may include input from formal and informal service providers and care givers as relevant to the personal outcomes; and
- Identifies areas where a professional evaluation is necessary to determine appropriate services or interventions.

5.3.4 RESPONSIBILITIES OF THE CASE MANAGER

The case manager is responsible for compiling and integrating formal/professional and informal information relevant to the development of an individualized CPOC. The case manager must:

- Assist in arranging professional/clinical evaluations and other components of the

assessment to develop strategies for obtaining the services, resources and supports needed to achieve the recipient's personal outcomes.

Note: Evaluations, tests, or reports are NOT covered case management activities. The necessary medical, psychological, psycho social or other clinical evaluations, tests, etc. may be covered by Medicaid or other funding sources.

- Identify, compile and review the array of formal assessments and other documents that are relevant to the recipient's needs, interests, strengths, preferences and desired personal outcomes.

- Obtain the recipient's authorization to secure appropriate services. In addition, a signed release of information must be obtained and a copy filed in the case record.

- Prepare the annual social summary.

- Report and document any incident/complaint/abuse to BCSS.
  Note: See Appendix D

- Provide any other requirements necessary for the recipients of the EDA waiver.

5.3.5 COMPREHENSIVE PLAN OF CARE

CPOC planning refers to a process whereby an analysis of information from the formal evaluations and the person-centered supports assessment is utilized. The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the recipient.

- The CPOC is developed through a collaborative process involving the recipient, family, friends or other support systems, the case manager and appropriate professionals/service providers and others who know the recipient best.

- The CPOC establishes direction for all persons involved in providing supports and services for the recipient, describing how the needed supports and services interact to form overall strategies that assist the recipient to maintain or achieve the desired personal outcomes.

- A CPOC ensures that the paid medical services and other resources are

medically necessary and meet the recipient's health and welfare needs as determined by the assessment. These services and resources are documented in the approved CPOC and are to be provided in a cost-effective manner.

- Current service providers must be involved in the development of the CPOC. The direct service provider's participation should relate to their ability to provide the requested service not determine what services are needed.

- The CPOC represents a strategy for ensuring that services are appropriate, available, and responsive to the recipient's changing goals and needs are updated by the assessment. The case manager should include the recipient's response/satisfaction to services previously received.

- The CPOC should not be considered a treatment plan. A treatment plan contains the specific clinical interventions which service providers prepare and use to achieve treatment or rehabilitation goals. The CPOC should be considered a "master plan". This plan consists of a comprehensive summary of information to aid the recipient to obtain assistance from formal and informal service providers as it relates to obtaining and maintaining their individual needs and desired personal outcomes.

Required CPOC Procedures

The CPOC meeting must be a face-to-face home visit with the recipient and members of his/her network, which may include family members, and must include service providers if already identified, appropriate professionals, and others who are well acquainted with the recipient. This meeting must be held at a time that is convenient for the recipient.

The CPOC must be outcome-oriented, individualized and time limited. Essential elements of the planning process include:

- Tailoring the CPOC to the recipient's needs based on the on-going person-centered assessment.

- Developing mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services.

- Assisting the recipient to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes which involves

assisting them to identify specific, realistic needs and choices for the CPOC.

- Assisting the recipient in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes, including action steps, review dates and individuals who will be responsible for specific steps.

- The CPOC must incorporate steps which empower and help the recipient to develop independence, growth, and self management.

- The CPOC must not be completed prior to the CPOC meeting.

- The annual CPOC is not a substitute for the quarterly review. Material and information developed as part of the quarterly review should be used to plan.

- The recipient, case manager, members of the family/natural support system, direct service providers, and appropriate professional personnel must be directly involved in the development of the CPOC.

- The CPOC must be written in language that is understandable to all parties involved. Specific problems due to a diagnosis or situation that causes a problem for the recipient must be clearly explained.

- Signatures of all participants are required.

- BCSS must approve the CPOC before issuing PAs and the initiation of services.

- No service will be prior authorized or delivered until all eligibility is met.

Required CPOC Components

The CPOC must incorporate the following required components:

- The recipient's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal natural/community supports and if needed paid formal services;

- Budget payment mechanism, as applicable;

- Target/resolution dates for the achievement/maintenance of personal outcomes;

- The CPOC must include the frequency and location of the case managers face-to-face contacts with the recipient, service providers, and others in the support network.

- Assigned responsibilities:

  - Identifying the preferred formal and informal service providers and specifying the service arrangements.

  - Identifying individuals who will assist the case manager in planning, building/implementing supports, or direct services.

  - Provide information to the recipient regarding appropriate Medicaid services.

  - Assist in planning for flexibility in frequency, intensity, location, time and method of each service or intervention, and plan cost is documented and consistent with the CPOC and recipient's desired outcomes.

  - Obtain Freedom of Choice (FOC) form with the names of local providers enrolled in Medicaid.

  - Changes in waiver service provider(s) can only be requested by the recipient; any request for a change requires a completion of a FOC form.

  - All participants present at the CPOC meeting must sign the CPOC. The CPOC must contain a signature of the recipient or responsible party indicating their agreement with the CPOC.

  Note: ***BCSS Regional Office staff responsible for review and approval of CPOCs will not consider a plan for approval unless there is a signature by the recipient or responsible party indicating their agreement with the CPOC. Without a signature there is no documentation that the ID team reached a consensus regarding the services described on the plan.***

  - The CPOC must be completed and approved as per CPOC instructions (Appendix B).

  - The recipient must be informed of his or her right to refuse a CPOC after carefully reviewing it and the process for complaint resolution.

- PAs shall not begin prior to the admission date on the 51-NH.

Note: After the initial CPOC is completed, all billable ongoing case management services must be provided according to the current approved CPOC.

Required CPOC Time Frames

The completed CPOC and financial eligibility documents must be completed and received by BCSS Regional Office within thirty-five (35) calendar days from the date of the linkage by BCSS or designee. All incomplete packets will be returned.

- The CPOC must be revised annually or as necessary to meet the needs of the recipient and must be reflected in the approved revised CPOC and submitted to the BCSS Regional Office no later than 35 calendar days prior to expiration.

- The CPOC must be reviewed at least quarterly to ensure that the personal outcomes and support strategies are consistent with the needs and desires of the recipient.

- Routine changes must be submitted fifteen (15) working days prior to the change (vacations, family schedules).

- Emergency changes must be submitted within twenty-four(24) hours or the next working day.

Changes in The CPOC

- If there are significant changes in the way the recipient defines or prioritizes the personal outcomes, and/or if there are significant changes in the support strategies or service providers, the case manager must revise the CPOC to reflect these changes. The revisions to the CPOC must identify the recipient's new service needs, outline goals/needed supports and targeted outcome for the recipient based on the IDT meeting. A BCSS revision change form, BCSS 11-R must be submitted to the BCSS Regional Office for approval for all Elderly and Disabled Adult waiver recipients.

- Upon receipt of the approved revisions, BCSS or designee will issue PAs to the service providers.

- A comprehensive review of the CPOC must be completed at a minimum of

contained in the CPOC are consistent with the needs of the recipient.

- The case manager must notify the direct service provider(s) regarding the time and place of the quarterly review and encourage their participation.

5.3.6 BUILDING AND IMPLEMENTING SUPPORTS

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

Responsibilities of the Case Manager

The case manager is responsible for assisting to build and implement the supports and services as described in the approved CPOC. The case manager is responsible for:

- Assisting the recipient to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the approved CPOC.

- Being knowledgeable of potential community resources, including formal resources (Food Stamps, SSI, housing, etc.)

- Knowledgeable of all Medicaid services and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.

- Communicating, as often as necessary, coordinating and problem solving with support and service providers.

- Assisting the recipient to initiate, develop and maintain a natural support network and to obtain the services identified in the approved CPOC assuring that they meet the recipient's individual needs.

- Training and supporting the recipient to become an independent self advocate to select providers and utilize community resources to achieve and maintain his/her desired outcomes.

- Advocate on behalf of the recipient to help establish, expand, maintain and strengthen the natural support network, and obtain appropriate services. This

strengthen the natural support network, and obtain appropriate services. This may involve calling and/or visiting recipients, community groups, organizations or agencies with or on behalf of the recipient.

- Requesting services compliant with all Medicaid rules and regulations.

- Oversight of the service providers to ensure that the recipient receives appropriate services and outcomes as designated in the approved CPOC. CPOC approval must be received prior to initiating and delivery of services. No service will be prior authorized or delivered until all eligibility is met. The PA for direct service providers will begin on the date BCSS issues the 51-NH.

- Provide a copy of the approved CPOC and any subsequent revisions for the home record book and all direct waiver service providers for their files.

- Assure a copy of the approved CPOC is made available to all staff directly involved with the recipient.

- Assisting the recipient to overcome obstacles, recognizing potential opportunities, and developing creative opportunities.

- Meeting with the recipient in a face-to-face home visit, at least once per quarter or more often if necessary to meet the individual's needs. This should be documented in the CPOC.

- When preparing quarterly summary, case manager must indicate the dates of services being reviewed and commented on. (Actual time period being reviewed (ex. April 27, 2002 to July 27, 2002)

Note: ***Advocacy is defined as assuring that the recipient receives appropriate services of high quality and locating additional services not readily available in the community.***

Note: ***After the initial CPOC is completed, all billable ongoing case management services must be provided according to the current approved CPOC.***

5.3.7 MONITORING SUPPORT STRATEGIES

The case manager and the recipient develop an action plan to monitor and evaluate strategies to ensure continued progress toward the recipient's personal outcomes.

Procedures for Monitoring Support Strategies

The case manager must contact the recipient within ten (10) working days after the initial CPOC is approved and after services begin to assure the appropriateness and adequacy of the service delivery.

- Monitor the service provider(s) no less than quarterly. This ongoing monitoring assesses the effectiveness of the support strategies and identifies changes in the recipient's needs or other health and welfare concerns. All components should be monitored and the frequency and intensity must be adjusted to meet the needs of the recipient. Records must be kept of all monitoring in a separate file. The components of the required monitoring are as follows:

  - Monitoring at the formal service provider's place of business

  - Review of the Remittance Advice (RA) is required only if the services are not provided. Copies of the RA are required only if there is a discrepancy. Any discrepancy of improper billing shall be reported to BCSS Regional Office.

  - Review and obtain copies of the progress notes from the service provider's case records to ensure they reflect the services provided. The progress notes must describe the recipient's progress toward goals and must be maintained in the recipient's case record.

  - Progress notes must reflect any meetings with service providers and the content of the discussion regarding working toward or obtaining recipient's personal outcomes.

  - Review deficiencies found in previous reviews conducted by the case management agency or BCSS Monitoring Unit to ensure corrective action has been taken. If corrective action has not been taken or is inadequate, the case management agency must notify BCSS Regional office.

  - Observation of Services

    The case manager must observe the services delivered by the formal direct service provider. This monitoring may be incorporated into the required quarterly home visit if the service provider is present and the service is routinely delivered in the home. Services must be monitored

where they are delivered.

- Review of the service provider's current log. Check to see if it is correct and current. Make a note of where it is kept. The log may contain such items as:

  - Progress notes,
  - Time sheets,
  - Medication administration forms,
  - Delegation forms,
  - Emergency evacuation plans, and
  - Emergency phone numbers.
  - Does the recipient feel he/she is meeting his/her outcome? Are the times convenient and satisfactory to the recipient?
  - Are the services provided adequate and of quality?
  - Are the providers present at the times indicated?
  - Review service provider plan of care to ensure all approved CPOC revisions are incorporated.

- Attend meetings with other service providers

  - The case manager shall have progress notes that reflect the discussion in these meetings and the progress towards the outcomes.

  - Make unscheduled home visits to verify service provider is actually in the home per the schedule on the approved CPOC.

- Telephone call

  - The case manager must do periodic telephone monitoring to verify the service provider is in the home and a log should be maintained in the recipient's case record. Include recipient name, provider name, time, date and activity. Deficiencies found shall be noted in the monitoring file.

- Inform the recipient as to the necessity to contact the case manager of significant changes in his/her status or if problems arise with his/her service providers. A major change in status requires a reassessment.

- Inform recipient of the BCSS toll free 1-800-660-0488 Helpline.

- Notify service providers within 3 working days of written changes in the approved CPOC.

- Monitor waiver providers for compliance with EDA waiver standards and report non-compliance to the BCSS Regional Office.

- Meet with the recipient in his/her home quarterly or more frequently if necessary to evaluate effectiveness of the support strategies and if necessary, the revision of the CPOC.

- Document the quarterly visits in the case record using quarterly progress notes. Other contacts and follow up which occur more frequently can be documented in the case notes and do not require the use of quarterly progress notes. Progress notes may be brief as long as all required components are addressed. Information documented in the progress notes do not need to be duplicated in the case record.

- Quarterly progress notes must address personal outcomes separately and reflect the recipient's interpretation of the outcomes. The quarterly progress notes must address at least the following issues:

  - Desired personal outcomes,
  - Strategies to achieve the outcomes,
  - Effectiveness of the strategies,
  - Obstacles to achieving the desired outcomes,
  - New opportunities,
  - Developing a new action plan.

Note: All contacts shall be entered no less than monthly into CMIS. No billing for the month shall occur until all contacts have been entered into CMIS.

5.3.8 CASE MANAGEMENT TRANSITION/CLOSURE

The transition or closure of case management services for recipients in the EDA waiver must occur in response to the request of the recipient or if the recipient is no longer eligible for services as described below. The closure process must ease the transition to other services or care systems.

Closure Criteria

Case management services closure criteria include but are not limited to the following:

- The recipient requests termination of services.
- Death of the recipient.
- Permanent relocation of the recipient out of the service area.
- Long term admission to a hospital, institution or nursing facility.
- Does not meet the criteria for EDA waiver case management established by the funding source (Medicaid).
- The recipient requires a level of care beyond that which can safely be provided through case management.
- The safety of the case manager is in question. The case management agency must contact BCSS Regional office to discuss the situation.
- 30-day continuity of stay- if the individual does not receive a waiver service within 30 consecutive days, they are ineligible for services. Case management is not a EDA waiver service. There are exceptions such as hospitalization.
- If an individual is institutionalized, the case manager must contact the BCSS Regional office to discuss the situation. The case manager must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services.
- Recipient refuses to comply with case management and BCSS requirements.
- The case management agency closes (see transfer procedures).
- The recipient no longer meets all eligibility requirements for EDA waiver participation.
- The recipient is discharged from waiver.

Note: ***If the recipient refuses to comply with case management requirements or the recipient does not receive any waiver services as required by the 30 day continuity of stay, the case manager must document all instances appropriately and contact BCSS Regional Office immediately.***

Required Transition/Closure Procedures

- Transition/closure decisions should be reached with the full participation of the recipient. If a recipient becomes ineligible for services, the case manager must notify the recipient and BCSS Regional office immediately.

Note: ***If the recipient's case is closed as a result of non compliance with Medicaid and waiver requirements, a note must be made to the record regarding the***

recipient's response to the case closure.

- The case manager must complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient methods of negotiating their own service needs.

- The case management agency must notify the BCSS of the transition/closure four weeks prior to the closure to allow BCSS to establish a transition plan. Send the closure notice to the following address:

  DHH Bureau of Community Supports and Services
  Case Management Program Administrator
  446 North 12th Street
  Baton Rouge, Louisiana 70802-4613

- The agency must follow their own policies and procedures regarding intake and closure.

- A case closure/transfer discharge summary must be prepared by the case manager within 14 calendar days of discharge and submitted to the BCSS Regional office.

- The case manager must assure that the receiving agency, program or case manager receives copies of the most current approved CPOC, any revisions to the CPOC and related documents such as:

  - Forms - 142, 18 LTC, 51NH,
  - Most current 6 months of progress notes,
  - Social evaluations and any updates,
  - Psychological evaluation and any updates,
  - Most current 90-L,
  - Current MR/DD 14's,
  - Any environmental modifications/assistive devices and any documentation on usage of lifetime limits,
  - Revisions to a prior CPOC,
  - CMIS Complexity Scale,
  - Physician delegation forms for current CPOC,
  - Home health plans,
  - Service provider plans of care
  - Psychiatric notes.

(The 148 must be completed to reflect the date of the transfer of records and submitted to the BCSS Regional office, BCSS or designee and the local parish Medicaid office.)

- The case manager must notify all service providers including the personal emergency response system provider listed on the approved CPOC when recipient's case is closed or transferred.
- The case manager must provide assistance to the recipient and to the receiving agency, program or case manager to assure a smooth transition.

- The case management agency must serve as a resource in coordinating of services to the recipients who choose to assume responsibility for coordinating some or all of their own services and supports, or who choose to ask a member of their network of support to assume some or all of these responsibilities.

Note: All closures must be entered into CMIS immediately.

5.3.9 PROCEDURES FOR CHANGING CASE MANAGEMENT AGENCIES

General Procedures For EDA Waiver Case Managers

A recipient may change case management agencies once after a six (6) month period and for "Good Cause" provided that the new agency has not met the maximum number of recipients allowed. "Good Cause" is defined as:

- The recipient moves to a different DHH region;

- The recipient and case management agency have unresolved difficulties and mutually agree to a transfer. This transfer must be approved by the BCSS Case Management Program Administrator.
- The EDA waiver population must be prior authorized; see the procedures for prior authorization in Section 7.

- Once the recipient has selected a new case management provider and has been linked, the new provider must complete the FOC file transfer form.

- Upon receipt of the completed form, the transferring case management agency must provide copies of the following information:

  - Most current approved CPOC and any subsequent revisions,
  - Current assessments on which CPOC is based,

- Number, type and units of services used in the calendar year,
- Current and previous quarter's progress notes,
- PA and Form MR/DD-14 (For EDA waiver participants),
- Forms - 142, 18 LTC, 51NH,
- Most current 6 months of progress notes
- Social evaluations and any updates,
- Psychological evaluation and any updates,
- Most current 90-L,
- Current MR/DD 14's,
- Any environmental modifications/assistive devices and any documentation on usage of lifetime limits,
- CMIS Complexity Scale,
- Physician delegation forms for current CPOC,
- Home health plans,
- Service provider plans of care,
- Psychiatric notes.

(The 148 must be completed to reflect the date of the transfer of records and submitted to the BCSS Regional office, BCSS or designee and the local parish Medicaid office.)

- The new case management agency must bear the cost of copying which cannot exceed the community's competitive copying rate. If the information is not received by the new case management agency in a timely fashion, or if the information is incomplete, the appropriate BCSS Regional office should be contacted for assistance.

- The transferring case management agency shall provide services up to the transfer of records and may bill for services after dated notification is received (transfer of records) by the receiving case management agency. In the month the transfer occurs, the receiving case management agency shall begin services within three working days after the transfer of records and may bill for services the first full month after the transfer of records. The receiving case management agency must submit the required documentation to BCSS or designee to begin prior authorization immediately after the transfer of records.

5.4 INFANTS AND TODDLERS

5.4.1 ELIGIBILITY

Infants and toddlers ages birth through two (2) inclusive (services are discontinued at age 3) must meet the following ChildNet Program eligibility criteria:

- A documented established medical condition determined by a licensed physician. In the case of a hearing impairment, a licensed audiologist or licensed physician must make the determination,

OR

- A developmental delay in one or more of the following areas:
  - Cognitive development
  - Physical development, including vision and hearing eligibility must be based on a documented diagnosis made by a licensed physician (vision) or a licensed physician or licensed audiologist (hearing)
  - Communication development
  - Social or emotional development
  - Adaptive development.

  The determination of a developmental delay must be made by a multi-disciplinary evaluation team which includes the child's family and qualified professionals, as recognized by the Louisiana Department of Education. ***The point of entry for all Infants and Toddlers is the written referral from the Department of Education's Child Search Coordinator.***

5.4.2 INTAKE PROCESS

Intake for infants and toddlers eligible under ChildNet is defined as a comprehensive, interagency, multi-disciplinary, ongoing process which ensures that eligible children are appropriately identified, located, referred, and evaluated for early intervention services. The local education agency's child search coordinator is the single point of entry into ChildNet and family service coordination (case management) services for infants and toddlers with

special needs. Upon receipt of a referral, the child search coordinator is responsible for completion of all intake procedures as listed below.

- Assist the family in selection of an enrolled family service coordinator. Referrals received directly by a family service coordination provider must be immediately referred to the appropriate child search coordinator for intake screening.

- The child search coordinator must provide the family freedom of choice form in selecting a DHH-enrolled family service coordination provider. The child search coordinator will notify the case management agency of the recipient's choice.

- Advise the family of their procedural safeguards, i.e. the right to change their family service coordinators/case management agency, and other service providers and provide them with a copy of their rights under ChildNet.

- Provide the family service coordinator with appropriate documentation of required intake activities.

- Advise the family of all available services including all EPSDT and personal care services (PCS) the child may require.

5.4.3 ASSESSMENT

The multi-disciplinary evaluation (MDE) is the ChildNet assessment. The MDE is the determination of a recipient's initial and continuing eligibility, and the collection of initial planning information for the development of the Individualized Family Service Plan (IFSP). It functions as the Comprehensive Plan of Care.

- The family service coordinator's (FSC) (case manager's) responsibilities in the MDE process must include:

  - Informing the family of the steps involved in the MDE process and explaining their rights and procedural safeguards and securing their level of desired participation.

  - Reviewing relevant medical records and prior evaluations.

  - Coordinating the necessary evaluations and KIDMED screenings and immunizations.

- Coordinating the necessary evaluations and KIDMED screenings and immunizations.
- Identifying and coordinating the identification of families' needs, concerns, priorities and resources.
- Developing the child's IFSP within required limits.
- Informing the recipient of all service choices.

- All multi-disciplinary evaluations must:
  - Be conducted by personnel trained to use appropriate methods and procedures.
  - Be based on informed clinical opinion of the multi-disciplinary evaluation team, including the family.
  - Be derived from multi-source data such as family information, observations, informed assessment procedures and the results of appropriate formal instruments, that comply with the nondiscriminatory procedures set forth in the ChildNet procedures.
  - Include the following:
    - A review of pertinent records related to the child's current health status and medical history.
    - Results of a KIDMED screening on a Medicaid-eligible child.
    - An evaluation of the child's level of functioning in each of the following developmental areas:
      - Cognitive development,
      - Physical development, including vision by a licensed physician) and hearing (by a licensed physician or licensed audiologist);
      - Communication development;
      - Social or emotional development; and

- Adaptive development

- An assessment of the child's strengths and needs and the identification of appropriate early intervention services to meet those needs.

- Identification of the family's concerns, priorities and resources related to enhancing their child's development.

- Be signed and dated by multi-disciplinary team participants.

Reassessment

- A review of the IFSP must be conducted at least every six (6) months, or more often if conditions warrant, or if the family requests a review to determine the following:

  - The degree to which progress is being made toward achieving the outcomes; and

  - Whether modifications or revisions of the outcomes or services are necessary.

  - Inform recipients of rights to change providers.

- The review may be carried out by a meeting or by other means that are acceptable to the family and other participants.

- These periodic reviews of the IFSP must include the parents, family service coordinator, and others at the parent's request.

  Note: ***If the person(s) involved in conducting evaluations and assessments is unable to attend the annual IFSP meeting, arrangements must be made for their involvement through other means such as telephone conference calls, a knowledgeable authorized representative attending the meeting, or the availability of pertinent records for the meeting.***

5.4.4 RESPONSIBILITIES OF THE FAMILY SERVICE COORDINATOR

- The family service coordinator (case manager) is responsible for:

- Coordinating the IFSP and other services across agency and provider lines.
- Serving as the single point of contact for helping the family obtain the needed services.
- Assisting the family in identifying and obtaining available service providers of the family's choice.
- Serving as a family advocate and informing them of the availability of advocacy services and parent support organizations available in the community.
- Conducting, at a minimum, a quarterly face-to-face visit. The child must be seen. More visits must occur if they are required to ensure the recipient meets the identified outcomes; shall be in the home if the recipient requests.

- Family service coordination is an active, ongoing process that empowers the family. These activities include:
  - Assisting the family to obtain early intervention services and other services identified in the IFSP.
  - Assisting the family to obtain alternative funding for services not covered by Medicaid or insurance and assisting families to complete insurance and other forms.
  - Coordinating the timely delivery of services.
  - Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility for case management services. The family service coordinator must work in a collaborative manner and with the full agreement and participation of the family including sensitivity to the coping strategies and the cultural and ethnic practices of the family.

5.4.5 DEVELOPMENT OF THE INDIVIDUAL FAMILY SERVICE PLAN

The Individualized Family Service Plan (IFSP) is a written plan for providing early intervention

services for ChildNet eligible children and their families. The determination of the most appropriate early intervention services, including any modification in service delivery or service providers is accomplished through the IFSP.

- The IFSP must:
  - Be developed by the family, appropriate qualified personnel, and the family service coordinators involved in the provision of early intervention services.
  - Be based on the multi-disciplinary evaluation and assessment of the child and family.
  - Include the services necessary to enhance the development of the child and the family's capacity to meet the special needs of their child.
  - Continue until early intervention services are terminated either to other appropriate service provider(s) or when the family and multi-disciplinary professionals determine that services are no longer necessary or the family no longer desires early intervention services.
  - Identify the location of the early intervention services to be provided in natural environments, including the home and community settings, in which children without special needs would participate.
- The initial IFSP meeting must be conducted within 45 calendar days from the date of receipt of referral by the child search coordinator.
- Required IFSP Meeting Procedures

  The IFSP is an interactive process which allows for full participation of the family and must comply with the following criteria:
  - Be conducted in settings and at times that are convenient for the families.
  - The family and other participants must receive sufficient written notice before the meeting date to ensure their attendance.
  - The written notice must be in language understandable to parents, include parental rights and procedural safeguards, and in sufficient detail to inform them about the proposed services.

- IFSP participants may include:
  - Parents.
  - Other family members requested by the parents, if feasible.
  - Family service coordinator.
  - Person directly involved in conducting the evaluation and assessments.
  - Service providers, as appropriate.
  - Advocates and other persons requested by the parents.

  Note: ***If the person(s) involved in conducting evaluations and assessments is unable to attend the IFSP meeting, arrangements must be made for his/her involvement in the meeting such as telephone conference calls, a knowledgeable authorized representative attending the meeting, or the availability of pertinent records for the meeting.***

- Required Components of an IFSP
  - A statement of the child's present levels of physical development, including vision, hearing, dental and health status; cognitive development, communication development, social, or emotional development; and adaptive development. This information must be based on written professionally accepted, objective criteria.
  - A statement of the family's identification of their strengths and needs, including concerns, priorities and resources related to enhancing the child's development. This statement may only be made with the concurrence of the family.
  - A statement of the major outcomes expected to be achieved including the criteria, procedures and time lines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications of the outcomes or services are necessary.
  - A statement of specific early intervention services necessary to meet the unique needs and the expected outcomes of the child and family, including

the frequency (number of days that a service will be provided), intensity (length of time the service is provided during each session and whether the service is provided on an individual or group basis), location (place where service is provided), method of delivering services (how a service is provided), and payment arrangements.

- A statement about the natural environment in which early intervention services will be provided.

- Medical and other services necessary to the child but not required in the early intervention system must be listed on the IFSP with the funding source. The family service coordinator must assist the family in gaining services such as KIDMED, WIC and immunizations.

- A statement of projected dates for initiation of the early intervention services as soon as possible after the IFSP meeting and the anticipated duration of those services.

- The name and telephone number of the family service coordinator from the profession most immediately relevant to the child's or family's needs, or who is otherwise qualified to carry out all responsibilities of the family service coordinator, who is responsible for the implementation of the IFSP and coordination with other agencies and persons.

- A statement identifying the child's status concerning Medicaid eligibility and a statement indicating the status of insurance paying for early intervention services.

In order to ensure that all of the components required in the IFSP are included, the IFSP form utilized by the case management agency must be approved by the Department of Education, the lead agency in administering the ChildNet program.

Annual IFSP Meeting

An annual meeting must be conducted to evaluate the IFSP and to revise the it. The results of any ongoing assessments of the child and family and any other pertinent information must be used in determining what early intervention services are needed and will be provided.

Note: Informed written consent must be obtained from the parents prior to the provision of the early intervention services identified on the IFSP.

5.4.6 TRANSITION AND CLOSURE

Transition moves the child from early intervention services to preschool services under Part B of IDEA toddler services or otherwise terminating early intervention services.

- A referral must be made to the local education agency at least ten (10) months prior to the child's third birthday to initiate the transition process.
    - For those children who begin receiving family service coordination after 24 months of age, transition planning must be addressed at the initial IFSP meeting.
    - 90 days prior to the child's third birthday, the FSC must convene a meeting with the family and local education agency to discuss the transition to the preschool program.
    - The FSC must develop and coordinate the transition process that prepares the child and family and all involved agencies.
- All Medicaid-funded family service coordination services must be terminated no later than the child's third birthday.
- All cases which do not have an active IFSP and necessary linkage or monitoring activities must be closed.
- The FSC must assist the family with arranging access to any remaining needed services prior to closure.

5.4.7 CHANGING PROVIDERS

If a family wishes to change their family service coordinator or family service coordination\case management agency or a change is necessary for any reason, the following procedures will be followed.

- The family will be referred to the child search coordinator. This referral can be made by the family, the current family service coordinator, or other service providers.
- The child search coordinator will provide the family with the official list of family service coordination providers and the freedom of choice form.

- The child search coordinator will review the family's rights under ChildNet with the family including the right to change family service coordinators or agencies every six months.

- The child search coordinator will notify the newly selected agency and the old agency of termination.

- After receiving written, informed, paternal, consent, the new agency will request records from the previous agency. The previous agency will make these records available within ten (10) working days of receipt of the request.

- The case management agency contacts BCSS or designee for prior authorization of case management services.

5.5 EPSDT TARGETED POPULATION

5.5.1 ELIGIBILITY

Recipients who are between the ages of 0 and twenty one (21) years old (eligibility for case management services ends on the recipients 21st birthday) on the MR/DD waiver Request for Services Registry (RFSR) and meet the specified eligibility criteria as follows:

- Placement on the MR/DD Waiver Request for Services Registry (RFSR) on or after October 20, 1997 and have passed the OCDD Diagnosis and Evaluation (D&E) process by the later of: October 20, 1997, or the date they were placed on the RFSR;

  OR

- Placement on the MR/DD Waiver RFSR on or after October 20, 1997 but who did not have a D&E by the later of: October 20, 1997 or the date they were placed on the MR/DD RFSR. Those in this group who subsequently pass or passed the D&E process are eligible for these targeted case management services. For those who do not pass the D&E process or who are not undergoing a D&E, they may still receive case management services if they meet the definition of a person with special needs.

  Special needs is defined as a documented, established medical condition, as determined by a licensed physician, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational, and other services. In the case of a hearing impairment, the determination of special needs must be made by a licensed audiologist or physician.

- Documentation that substantiates that the EPSDT recipient meets the definition of special needs for case management services includes but is not limited to:

  - Receipt of special education services through the state or local education agency;

    OR

  - Receipt of regular services from one or more physicians;

OR

- Receipt of or application for financial assistance such as SSI because of a medical condition, or the unemployment of the parent due to the need to provide specialized care for the child;

OR

- A report by the recipient's physician of multiple health or family issues that impact the recipient's ongoing care;

OR

- A determination of developmental delay based upon the Parent's Evaluation of Pediatric Status, the Brignance Screens, the Child Development Inventories, Denver Developmental Assessment, or any other nationally recognized diagnostic tool.

5.5.2 INTAKE

Intake is the entry point into case management. The purpose of the intake process is to evaluate the applicants request for case management services.

Required Intake

These case management intake procedures are applicable for EPSDT recipients. Referrals for case management services are from the Bureau of Community Supports and Services (BCSS) or designee. The required procedures of intake screening for EPSDT recipients are as follows:

- Interview the recipient within three (3) working days of receipt of the freedom of choice (FOC) form, preferably face-to-face in the recipient's home, and obtain required DHH demographic information.

- The initial intake process is as follows:

  - When BCSS or designee notifies the case management agency of the recipient's choice, the case manager begins the CPOC process. Upon approval of the required information, the case management agency will be issued prior authorization to cover services from the beginning date of the CPOC. The BCSS will transfer eligibility documents with the transfer of

records.

- The case manager shall use MEVS/REVS to determine if the recipient is eligible and remains eligible for Medicaid. Reimbursement will only be made for Medicaid recipients. If the recipient becomes ineligible for Medicaid or case management services, notify the recipient/family and BCSS Regional Office immediately and direct the recipient to other service options or to the source of the initial referral.

*Note: **The case manager shall check for continued eligibility monthly**.*

- Determine the need for immediate case management intervention.

- Determine if the recipient accepts case management and the requirements of face-to-face visits (preferably in the home).

- Inform the recipient/family of procedural safeguards, rights and grievance procedures which include the following:

  - Advise the recipient/family of their rights and responsibilities including the right to change case management providers and case managers. Advise the recipient/family of their right to change case management providers once at the end of a six month linkage. Documentation of information must be noted and maintained in the recipient's record.

  - The recipient/family must sign a standardized intake form to verify the above procedural safeguards.

  - The availability of formal and non-formal services.

  - Availability of the BCSS toll free 1-800-660-0488 Helpline.

  - Collect information on the health needs of the recipient.

  - Obtain signed release of information form(s) from the recipient/family.

  - Determine if the recipient is receiving case management from another provider for the same or different type of case management. If so, please notify the other case management

agency immediately and follow the procedures for changing providers described in this manual. If the recipient is receiving any type of waiver case management the EPSDT-Targeted case will be closed.

- Explain to recipient/family all Medicaid services with special emphasis on DME, EPSDT, (PCS, KIDMED) and home health.

5.5.3 ASSESSMENT

Assessment is defined as the process of compiling and integrating formal/professional and informal information relevant to the development of a person centered CPOC which is based on, and responsive to the recipient's desired personal outcomes, functional status, and current service needs. The assessment provides foundation for case management by defining the recipient's needs and assisting in the development of the mandatory CPOC.

Required Ongoing Assessment Procedures

The assessment must be ongoing to reflect changes in the recipient's life and the changing prioritized personal outcomes over time. These changes include strengths, needs, preferences, abilities, and the resources of the recipient. If there are significant changes in the status of the recipient or his/her prioritized needs, the case manager must revise the CPOC.

Time Frames for Assessment

- The initial assessment must begin within seven (7) calendar days of the referral and be completed within 30 calendar days of the referral.

- A reassessment may be conducted at any time, particularly with a significant change, but must be completed within 7 calendar days of notice of a change in the recipient's status.

- Quarterly (typically every 90 days from the date of the CPOC), the case manager and the recipient/family shall review the CPOC to determine if the recipient's needs continue to be addressed. In addition, discussion of all Medicaid services, especially DME, EPSDT (PCS & KIDMED) and home health are required.

- Annually (prior to the annual update of the CPOC)

Assessment Process

The person-centered supports assessment must be conducted by the case manager and consists of the following:

- Coordinating the necessary evaluations and KIDMED screenings and immunizations
- Reviewing relevant medical records and prior evaluations
- Informing the recipient/family of all service choices particularly Medicaid services: DME, EPSDT, (PCS & KIDMED) and home health.
- Assisting the recipient/family to arrange professional evaluations and appointments including activating examination/diagnosis/treatment loop.
- Conducting face-to-face interviews with the recipient/family.

Characteristics and Components of the Assessment

- A standardized instrument for certain targeted populations;
- Identifying information;
- The personal outcomes envisioned, defined and prioritized by the recipient;
- Medical/physical;
- Psycho social/behavioral information and documentation;
- Developmental/intellectual information and documentation;
- Socialization/recreational information and documentation, including relationships that are important to the recipient and the social environment of the recipient;
- The patterns of the recipient's everyday life;
- Identification of natural supports;
- Information and documentation on financial resources;
- Educational/vocational information and documentation;
- Information on the current status of housing and the physical environment;
- Information about previously successful and unsuccessful strategies to achieve the recipient's desired personal outcomes;
- Any other information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes. Such information may include input from formal and informal service providers and care givers as relevant to the personal outcomes; and
- Identifies areas where a professional evaluation is necessary to determine appropriate services or interventions.

Reassessment

- Review of the CPOC must be conducted at least quarterly or more often if conditions warrant or at the recipient/family's request to determine the following:
  - The degree to which progress is being made toward achieving the outcomes.
  - Are services satisfactory and being delivered as planned?
  - Whether modifications or revisions of the outcomes or services are necessary
  - Is assistance required in accessing Medicaid services such as PCS and extended home health care services.
  - Discuss with recipient/family medical and social needs.
  - Inform the recipient/family of their right to change case management providers after a 6 month linkage.
  - Inform recipient/family of all Medicaid services.
- The review may be carried out by a meeting or by other means that are acceptable to the recipient/family and other participants.
- These periodic reviews of the CPOC must include the recipient (if underage the parent/legal guardian), the case manager, and others at the recipient/family's request.

5.5.4 RESPONSIBILITIES OF THE CASE MANAGER

The case manager is responsible for assisting to build and implement the supports and services as described in the approved CPOC. The case manager must:

- Identify, compile and review any necessary assessments and other documents that are relevant to the recipient/family's needs (including health needs), interests, strengths, preferences and desired outcomes.
- Assist in arranging professional evaluations and other components of the assessment to develop strategies for obtaining the services, (including EPSDT,

PCS services, and making referrals for KIDMED), resources and supports needed to achieve the recipient's personal outcomes.

- Be knowledgeable of potential community resources, including formal resources (Food Stamps, SSI, housing, etc.)
- Ensure recipient/family choice,
- Follow up with the recipient/family on a regular basis but no less than quarterly. At the quarterly face-to-face visit discuss with recipient/family if all services are appropriate and satisfactory and being delivered as planned or if changes are required.
- Assist the recipient/family to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient/family in the approved CPOC.
- Have knowledge of all Medicaid services and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.
- Assist and remove any barriers that the EPSDT recipient/family may have in obtaining the identified services.
- Advocate on behalf of the recipient/family to help establish, expand, maintain and strengthen the natural support network, and obtain appropriate services. This may involve calling and/or visiting recipient/family, community groups, organizations or agencies with or on behalf of the recipient/family.
- Inform the recipient/family no less than quarterly of all Medicaid services for which they maybe eligible.
- Prepare the annual CPOC and appropriate updates, assessments.
- Document in progress notes all discussion regarding Medicaid services.
- Keep the required documentation in the record as well as in the CMIS.

*Note: **Advocacy is defined as assuring that the recipient receives appropriate services of high quality and locating additional services not readily available***

in the community.

Note: After the initial CPOC is completed, all billable ongoing case management services must be provided according to the current approved CPOC.

5.5.5 COMPREHENSIVE PLAN OF CARE (CPOC)

CPOC planning refers to a process whereby an analysis of information from the formal evaluations and the person-centered supports assessment is utilized. The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the recipient/family.

- The CPOC is developed through a collaborative process involving the recipient, family, friends or other support systems, the case manager and others that know the recipient best.
- The CPOC must be completed in a face-to-face meeting with the recipient/family.
- The CPOC establishes direction for all persons involved in providing supports and services for the recipient, describing how the needed supports and services interact to form overall strategies that assist the recipient to maintain or achieve the desired personal outcomes.

Required CPOC Procedures

The CPOC must be a face-to-face visit with the recipient (if the recipient is a child, the child must at least be seen) and at a time and place that is convenient for the recipient/family. The face-to-face should be held in the home if the recipient/family requests, but a home visit is not mandatory.

The CPOC must be outcome oriented, individualized and time limited. Essential elements of the planning process include:

- Tailoring the CPOC to the recipient's needs based on the person-centered assessment,
- Developing mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services.

- Discussion with recipient/family about available Medicaid services such as DME, EPSDT, (PCS & KIDMED), and home health.

- Assisting the recipient/family to make informed choices about all aspects of supports and services needed to achieve their desired personal outcomes which involves assisting them to identify specific, realistic needs and choices for the CPOC.

- Assisting the recipient/family in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes.

- The CPOC must incorporate steps which empower and help the recipient to develop independence, growth and self management.

- The CPOC must not be completed prior to the CPOC meeting

Required CPOC Components

The CPOC must incorporate the following required components:

- The recipient's prioritized outcomes and specific strategies to achieve or maintain the desired outcomes.

- Targeted resolution dates for the achievement of personal outcomes.

- Assigned responsibilities.

- Identification of the preferred formal and informal service providers. These services are to include applicable Early Periodic Screening Diagnostic and Treatment (EPSDT) services available to Medicaid eligible children under age 21 (see Appendix A for an explanation of these services).

- Identification individuals who will assist the case manager in directing services.

Required CPOC Time Frames

- The completed CPOC must be completed and received by the BCSS Regional Office within thirty-five (35) calendar days from the date of the linkage. All incomplete packets will be returned.

- The CPOC must be revised annually or as required by significant changes in the

recipient's personal outcomes. The annual CPOC must be received by the BCSS Regional Office no later than 35 calendar days prior to the expiration date.

- Assessments must be done quarterly to assure that the CPOC continues to address the recipient's needs.
- Significant changes in the CPOC must be submitted within fifteen (15) days from the case managers knowledge of the change.
- Emergency changes must be submitted within 24 hours or the next working day.

Changes in the CPOC

- If there are significant changes in the way the recipient defines or prioritizes the personal outcomes or in their formal service needs, the CPOC must be revised. The annual CPOC date does not change.
- Receipt of the approved CPOC and/or any approved changes is not required to implement services for the EPSDT-Targeted populations.

Documentation

The CPOC must include the frequency and location of the case managers face-to-face contacts with the recipient and others in the support network.

A copy of the approved CPOC must be given to the recipient/family and a copy must be kept in the recipient's case record at the case management agency. A copy of the CPOC must be made available to all staff directly involved with the recipient.

5.5.6 BUILDING AND IMPLEMENTING SUPPORTS

The implementation of the CPOC involves informing the recipient of his/her service choices, arranging or assisting in arranging both informal and formal/professional services that will contribute to the achievement of the desired outcomes.

Note: ***The EPSDT-Targeted population is eligible for all Medicaid and EPSDT services, which may be implemented as soon as the need is identified. The CPOC does not have to be approved to implement services.***

Responsibilities of the Case Manager

The case manager is responsible for assisting in building and implementing supports as described in the CPOC:

- Assisting the recipient to use the findings of formal and informal assessments to implement and develop support strategies to achieve the personal outcomes defined and prioritized by the recipient in the CPOC.

- Being knowledgeable of all Medicaid services and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.

- Having knowledge of potential community resources, including formal resources (all Medicaid Services, Food Stamps, SSI, housing, etc.) and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his or her desired personal outcomes.

- Communicating and resolving problems with support and service providers.

- Assisting the recipient to initiate, develop and maintain a natural support network and to obtain the services identified in the CPOC and assuring that they meet his/her individual needs.

- Advocating for the recipient to assist him/her in obtaining appropriate benefits or services to help establish, expand, maintain and strengthen the natural support network. This may involve calling and/or visiting recipients, community groups, organizations or agencies with or on behalf of the recipient.
- Training and supporting the recipient to become an independent self advocate in selecting providers and how to utilize community resources to achieve and maintain his/her desired outcomes.

- Assisting the recipient to overcome obstacles, recognizing potential opportunities, and developing creative opportunities.

- Meeting with the recipient in a face-to-face home visit, at least once per quarter or more often if necessary to meet the individual's needs. This should be documented in the CPOC.

- When preparing quarterly summary, case manager must indicate the dates of services being discussed. (Actual time period being covered (ex. April 27,

2002 to July 27, 2002).

Note: ***Advocacy is defined as assuring that the recipient receives appropriate services of high quality and locating additional services not readily available in the community.***

5.5.7 Monitoring of Support Strategies

Monitoring of support strategies is not required of this population. The case manager must follow-up with the recipient to see that they are receiving the services described on the approved CPOC and to assist in removing any barriers they may have in obtaining any services. Special emphasis should be placed on any EPSDT services.

Note: ***All contacts shall be entered no less than monthly into CMIS. No billing for the month shall occur until all contacts have been entered into CMIS.***

5.5.8 CASE MANAGEMENT TRANSITION/CLOSURE

The transition or closure of case management services for recipients in EPSDT target population must occur in response to the request of the recipient/family or if the recipient is no longer eligible for services. The closure process must ease the transition to other services or care systems.

Closure Criteria

Case management services closure criteria include but are not limited to the following:

- The recipient/family requests termination of services;
- The recipient/family refuses services and/or refuses to comply with case management;
- Death of the recipient;
- The recipient is no longer Medicaid eligible;
- Permanent relocation of the recipient out of the service area;
- The safety of the case manager is in question. The case management agency must contact BCSS Regional office to discuss the situation;
- If an individual is institutionalized, the case manager must contact the BCSS Regional office to discuss the situation. The case manager must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services;
- Recipient refuses to comply with case management and BCSS requirements;

- The case management agency closes (see transfer procedures);
- Recipient is no longer eligible for EPSDT case management services.

Note: ***If the recipient refuses to comply with case management requirements, the case manager must document all instances appropriately and contact BCSS Regional Office immediately.***

Required Transition/Closure Procedures by the Case Manager

- Transition/closure decisions should be reached with the full participation of the recipient/family. If a recipient becomes ineligible for services, the case manager must notify the recipient/family and BCSS Regional Office immediately.

- At closure and 90 days prior to the recipients reaching their 21st birthday, the case manager must complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient/family methods of negotiating their own service needs.

- The case management agency must notify BCSS or designee and enter the case as closed in the CMIS immediately and no later than seven days after the closure.
- The agency must follow their own policies and procedures regarding intake and closure.

Transition of the Recipient into a Waiver

If the recipient becomes eligible for the waiver, a FOC form will be provided to the recipient/family by BCSS or designee to request services under the waiver.

The FOC form will be sent to BCSS or designee for linkage.

BCSS or designee will check to see if the recipient is currently receiving services and notify the receiving and transferring agencies of the linkage.

The recipient will be linked as per the established contract guidelines on agency capacity.

If the recipient/family chooses a different agency for waiver services BCSS or designee will forward all documents related to waiver criteria to the case management agency. The receiving agency is required to obtain any existing documentation from the previous EPSDT-Targeted Populations provider. The FOC Transfer of Records form shall be used. See Procedures For

Changing Providers below.

5.5.9 PROCEDURES FOR CHANGING PROVIDERS

General Procedures for Case Managers

A recipient may change case management agencies once after a six month period or for "Good Cause" at any time, provided that the new agency has not met maximum number of recipients. "Good Cause" is defined as:

- The recipient moves to a different DHH Administrative Region; or
- The recipient and case management agency have unresolved difficulties and mutually agree to a transfer. This transfer must be approved by the BCSS Case Management Program Administrator

Once the recipient/family has selected a new case management agency; BCSS or designee links them to a contract provider and notifies the recipient/family and the receiving and transferring agencies of the change in linkage. The receiving provider must complete the FOC file transfer form. Also, the provider must obtain the case record and authorized signature from the transferring case management agency.

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

- Most current CPOC
- Current assessment, KIDMED Screening, or other documents on which CPOC is based
- Current and previous quarter's progress notes

The transferring provider shall provide services up to the transfer of records and are eligible to bill for case management services in the month the transfer occurs. The receiving agency shall begin services within three days after the transfer of records and are eligible to bill for services the month after the transfer of records. The receiving agency must submit the required documentation to BCSS or designee to begin prior authorization immediately.

5.6 NURSE HOME VISITS FOR FIRST TIME MOTHERS

5.6.1 ELIGIBILITY

The recipient must meet all of the following eligibility requirements for this target population to receive Nurse Home Visits for First Time Mothers case management services:

To Determine Eligibility - Answer must be YES to all four (4) of the following questions:

- Is the potential participant a first-mother?
  - A first-time mother must be one (1) of the following:
    - A woman who is expecting her first live birth, has never parented and plans on parenting this child; or
    - A woman who is expecting her first live birth, has never parented and is contemplating placing the child for adoption; or
    - A woman who has been pregnant, but has not delivered a child due to abortion/miscarriage; or
    - A woman who is expecting her first live birth, but has parented stepchildren or younger siblings; or
    - A woman who has delivered a child, but her parental rights were legally terminated within the first few months of that child's life; or
    - A woman who has delivered a child, but the child died within the first few months of life.
- Is the potential participant Presumptively Eligible for Medicaid, or already on Medicaid?
- Is the potential participant less than 28 weeks pregnant?
- Does the potential participant reside in the specified geographic area?

5.6.2 INTAKE

The purpose of intake is to compile information to determine the recipient's eligibility for the program. During the intake process, the case manager nurse will compile the necessary information to determine the recipient's eligibility and desire for the program; describe the program, its benefits and drawbacks; and rights and responsibilities of the recipient.

Required Intake Procedures

These case management intake procedures are applicable for the Nurse Home Visits For First Time Mothers program. Referrals for case management services are self referrals, as well as from a variety of sources such as: schools, family members, Public Health Units, etc. The required procedures of intake screening are as follows:

- Interview the recipient within three (3) working days of receipt of the referral or request for case management services, preferably face-to-face in the home, and obtain required DHH demographic information.

- Determine if the recipient is eligible for services as indicated by medical and/or other applicable eligibility requirements of the Nurse Home Visits for First Time Mothers program. If the recipient is not Medicaid eligible, the case management agency will not be paid. Historically, one percent fall into this category. Medicaid will not reimburse for any referrals or assistance in the application process. The initial intake process is as follows:

  - Provide Freedom of Choice (FOC) form to the recipient, send to BCSS or designee for linkage.

  - Determine if the recipient's level of need require case management services.

  - Determine the need for immediate case management intervention.

  - Inform the recipient and family as appropriate of procedural safeguards, rights and grievance procedures which include the following:

    - Determine if the recipient accepts case management and the requirements of face-to-face home visits.

    - Advise the recipient of their right to change case management providers and case managers, the availability of services and case

management.

- The recipient must sign a standardized intake form to verify the above procedural safeguards.

- Availability of the BCSS toll free 1-800-660-0488 Helpline.

- Determine whether the recipient is receiving another type of case management service from another provider. If so, follow the procedures for changing case management service type described in this section.

- Obtain signed release of information form(s) from the recipient/family.

- If the recipient does not meet eligibility for case management services, notify the recipient/family immediately and direct the recipient to other service options, or to the source of the initial referral.

Note: ***Intake activities performed solely to determine eligibility and need for targeted case management for Nurse Home Visits for First Time Mothers are not billable to Medicaid.***

5.6.3 ASSESSMENT

Assessment is defined as the process of gathering and integrating formal/professional and informal information relevant to the development of the recipient's goals as envisioned and desired by the recipient. Assessment begins at the first home visit between the recipient and nurse case manager. The recipient's strengths, needs and personal desires are assessed in each of the six domains targeted within the Nurse Home Visits for First Time Mothers Program. These domains include:

- Personal Health
- Environmental Health
- Life Course Development
- Maternal Role
- Family and Friends
- Health and Human Services

Individualized goals are reviewed and updated at each visit and revised in collaboration between the nurse case manager and recipient and/or family. All assessments must be recorded in the recipient's record.

Time Frames for Assessment

- The initial assessment must begin within seven (7) calendar days of the referral and be completed within 30 calendar days of the referral.
- A reassessment may be conducted at any time, particularly with a significant change but must be completed within 7 calendar days of notice of a change in the recipient's status.
- Quarterly (typically every 90 days from the date of the CPOC), the case manager nurse and the recipient shall review the CPOC to determine if the recipient's needs continue to be addressed.
- Annually.

Assessment Process

The person-centered supports assessment must be conducted by the case manager nurse and consists of the following:

- Face-to-face home interviews with the recipient
- Direct observation of the recipient
- Direct contact with family and other natural supports
- Discussion with other professionals and support/service providers as indicated by the situation and the desires of the recipient
- Discussion of Freedom of choice, the availability of all services and the option of case management.
- Discussion of what the recipient requires from case management

Characteristics and Components of the Assessment

- A standardized instrument for certain targeted populations;
- Identifying information;
- The personal outcomes envisioned, defined and prioritized by the recipient;
- Medical/physical;
- Psycho social/behavioral information and documentation;
- Developmental/intellectual information and documentation;
- Socialization/recreational information and documentation, including relationships that are important to the recipient and the social environment of the recipient;
- The patterns of the recipient's everyday life;

- Identification of natural supports;
- Information and documentation on financial resources;
- Educational/vocational information and documentation;
- Information on the current status of housing and the physical environment;
- Information about previously successful and unsuccessful strategies to achieve the recipient's desired personal outcomes;
- Any other information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes. Such information may include input from formal and informal service providers and care givers as relevant to the personal outcomes; and
- Identifies areas where a professional evaluation is necessary to determine appropriate services or interventions.

5.6.4 RESPONSIBILITIES OF THE CASE MANAGER NURSE

The case manager nurse is responsible for compiling and integrating formal/professional and informal information relevant to the development of an individualized CPOC. The case manager nurse must:

- Assist in arranging professional/clinical evaluations and other components of the assessment to develop strategies for obtaining the services, resources and supports needed to achieve the recipient's personal outcomes.

  *Note: **Evaluations, tests, or reports are NOT covered case management activities. The necessary medical, psychological, psycho social or other clinical evaluations, tests, etc. may be covered by Medicaid or other funding sources.***

- Identify, compile and review the array of formal assessments and other documents that are relevant to the recipient's needs (including health needs), interests, strengths, preferences and desired personal outcomes.

- Obtain the recipient's authorization to secure appropriate services. In addition, a signed authorization for release of information must be obtained and a copy filed in the case record.

- Report and document any incident/complaint/abuse to appropriate authority.

5.6.5 DEVELOPMENT OF THE COMPREHENSIVE PLAN OF CARE

The Comprehensive Plan of Care (CPOC)

- Is developed through a collaborative process involving the recipient and the case manager nurse.
- Establishes the goals of the recipient.
- Represents a strategy for ensuring that services are appropriate and responsive to the recipient's needs as updated throughout the program.
- Must be individualized.
- Must be completed in the presence of the recipient.
- Will be completed within the first month of the first home visit, again within 25 days of the birth of the baby and at least 35 days prior to the baby's first birthday.
- Anytime there is a significant change in the goals/services for the recipient, there must be an updated CPOC submitted to the BCSS Regional Office within ten (10) working days from the change to the plan.

5.6.6 BUILDING AND IMPLEMENTING SUPPORTS

The case manager nurse involves the recipient in arranging, building, and implementing a continuum of both informal supports and formal/professional services to meet the recipient's needs as they relate to her desired goals.

In order to assist the recipient to identify; develop; and maintain strategies to attain personal goals, the case manager nurse will perform activities relating to the six identified program domains (Personal Health, Environmental Health, Life Course Development, Maternal Role, Family and Friends, and Health and Human Services). Protocols already set up in the program will serve as the basis and guide for interventions. Other resources may be used to enhance protocol material.

5.6.7 MONITORING OF SERVICES

The case manager nurse will monitor the recipient to ensure the current plan is

appropriate for the recipient's needs and that all appointments are being kept. Through face-to-face contact, attention will be given to the six domain to ensure that these and other individualized goals are being met. If additional services or special referrals are needed, the case manager nurse will assist the recipient in accessing these services.

5.6.8 TRANSITION AND CLOSURE

The recipient will be informed during intake of when/how closure will occur. The case manager nurse will assist the recipient in the transition or closure of services if the recipient is no longer eligible for services. The closure process must ease the transition to other services or care systems, if needed. Transition/closure decisions will be reached with the full participation of the recipient. If the recipient becomes ineligible for services, the case manager nurse will notify the recipient immediately and assist her in finding the services or supports she may need.

The case manager nurse will document, in the record, the reason(s) for closure and will indicate any referrals or other supportive services which are provided for the recipient at the time of closure. A case closure/transfer discharge summary must be prepared by the case manager nurse with 14 calendar days of discharge.

Criteria for closure of case management services include but are not limited to the following:

- The recipient/family requests termination of services;
- Death of the recipient;
- Loss of pregnancy;
- Stillbirth or death of infant/child;
- Loss of parental rights;
- The recipient/family refuses services and/or refuses to comply with case management;
- The recipient is no longer Medicaid eligible;
- Permanent relocation of the recipient out of the service area;
- The safety of the case manager nurse is in question; The case management agency must contact BCSS Regional office to discuss the situation.
- If an individual is institutionalized, the case manager must contact the BCSS Regional office to discuss the situation. The case manager must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services.
- Recipient refuses to comply with case management and BCSS requirements;
- The case management agency closes (see transfer procedures);or
- Recipient no longer meets the eligibility criteria for the program.

If a recipient's services are closed due to loss of pregnancy or stillbirth/death of the

infant/child, a limited number of additional nurse home visits will be offered. The nurse will assist the recipient in obtaining additional professional or other support as needed. The closure report from CMIS must be submitted to BCSS or designee.

Note: All closures must be entered into CMIS immediately.

Note: Recipients may not receive more than one type of Medicaid funded case management at a time.

5.7 HIV/AIDS

5.7.1 ELIGIBILITY

The recipient, regardless of age, must meet the following eligibility requirements for this target population in order to be enrolled in HIV infected case management services:

- Written verification of HIV infection by a licensed physician or laboratory test result is required

AND

- The adult recipient must have reached, as documented by a physician, a level 70 on the Karnofsky scale (or cares for self but is unable to carry on normal activity or do active work), at some time during the course of HIV infection

OR

The pediatric recipient (less than 21 years old) must display symptoms of illness related to HIV infection as documented by a licensed physician.

5.7.2 INTAKE

Intake is the entry point into case management. The purpose of the intake process is to evaluate the applicants request for case management services.

Required Intake

These case management intake procedures are applicable for HIV recipients. Referrals for case management services are self referrals, as well as, from a variety of sources such as: local public health units, emergency rooms, federally qualified health centers, family planning centers, homeless shelters, HIV counseling and testing sites, etc. The required intake procedures for HIV recipients are as follows:

- Interview the recipient within three (3) working days of receipt of the referral face-to-face preferably in the recipient's home or at another location as requested by recipient and obtain required DHH demographic information.

- Provide the recipient a freedom of choice (FOC) form and send it to BCSS or designee for linkage.

- Determine if the recipient is eligible for services as indicated by medical and/or other applicable eligibility requirements of the HIV targeted population described above. If the recipient is not Medicaid eligible, the case management agency will not be paid. Historically, one percent fall into this category. Medicaid will not reimburse for any referrals or assistance in the application process. The initial intake process is as follows:

  - The case manager begins the CPOC process. Upon approval of the required information, the case management agency will be issued prior authorization to cover services from the beginning date of the CPOC.

  - The case manager shall use MEVS/REVS to determine if the recipient is eligible and remains eligible for Medicaid. Reimbursement will only be made for Medicaid recipients. If the recipient becomes ineligible for Medicaid or case management services, notify the recipient immediately and direct the recipient to other service options or to the source of the initial referral.

  Note: The case manager shall check for continued eligibility monthly.

- Determine the need for immediate case management intervention.

- Determine if the recipient accepts case management and the requirements of face-to-face visits.

- Inform the recipient of procedural safeguards, rights and grievance procedures which include the following:

  - Advise the recipient of their rights and responsibilities including the right to change case management agencies and case managers. Documentation of information must be noted and maintained in the recipient's record.

  - The recipient must sign a standardized intake form to verify the above procedural safeguards.

  - The availability of formal and non-formal services.

  - Availability of the BCSS toll free 1-800-660-0488 Helpline.

  - Collect information on the health needs of the recipient.

- Obtain signed release of information form(s) from the recipient. Determine if the recipient is receiving case management from another provider. If so, follow the procedures for changing providers described in this manual.

- Explain to recipient all Medicaid services.

Note: Intake activities performed solely to determine eligibility and need for HIV targeted case management are not billable to Medicaid.

5.7.3 ASSESSMENT

Assessment is defined as the process of compiling and integrating formal/professional and informal information relevant to the development of an individualized CPOC which is based on and responsive to the recipient's desired personal outcomes, functional status, and current service needs. The assessment provides foundation for case management by defining the recipient's needs and assisting in the development of the CPOC.

Required Ongoing Assessment Procedures

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

Time Frames for Assessment

- The initial assessment must begin within seven (7) calendar days of the referral and be completed within 30 calendar days of the referral.

- A reassessment may be conducted at any time, particularly with a significant change, but must be completed within seven (7) calendar days of notice of a change in the recipient's status.

- Quarterly (typically every 90 days from the date of the CPOC), the case manager and the recipient shall review the CPOC to determine if the recipient's needs continue to be addressed.

- Annually

Assessment Process

The person-centered supports assessment must be conducted by the case manager and consists of the following:

- Face-to-face interviews with the recipient, preferably in the home unless recipient request otherwise.
- Direct observation of the recipient.
- Case manager should discuss with recipient if they wish to have contact with family and other natural supports for input into service planning of CPOC.
- Discussion with other professionals and support/service providers as indicated by the situation and the desires of the recipient.
- Discussion of Freedom of choice, and the availability of all services.
- Discussion of what the recipient requires from case management

Characteristics and Components of the Assessment

- A standardized instrument for certain targeted populations;
- Identifying information;
- The personal outcomes envisioned, defined and prioritized by the recipient;
- Medical/physical;
- Psycho social/behavioral information and documentation;
- Developmental/intellectual information and documentation;
- Socialization/recreational information and documentation, including relationships that are important to the recipient and the social environment of the recipient;
- The patterns of the recipient's everyday life;
- Identification of natural supports;
- Information and documentation on financial resources;
- Educational/vocational information and documentation;
- Information on the current status of housing and the physical environment;
- Information about previously successful and unsuccessful strategies to achieve the recipient's desired personal outcomes;
- Any other information relevant to understanding the supports and services needed by the recipient to achieve the desired personal outcomes. Such information may include input from formal and informal service providers and care givers as relevant to the personal outcomes; and
- Identifies areas where a professional evaluation is necessary to determine appropriate services or interventions.

Reassessment

- Review of the CPOC must be conducted at least quarterly or more often if conditions warrant, or at the recipient's request to determine the following:
  - The degree to which progress is being made toward achieving the outcomes.
  - Are services satisfactory and being delivered as planned?
  - Whether modifications or revisions of the outcomes or services are necessary.
  - Is assistance required in accessing Medicaid services?
  - Discuss with recipient medical and social needs.
  - Inform recipient of all Medicaid services.
- The review may be carried out by a meeting or by other means that are acceptable to the recipient and other participants.
- These periodic reviews of the CPOC must include the recipient, the case manager, and others at the recipient's request.

5.7.4 RESPONSIBILITIES OF THE CASE MANAGER

The case manager is responsible for assisting to build and implement the supports and services as described in the approved CPOC. The case manager must:

- Identify, compile and review any necessary assessments and other documents that are relevant to the recipient's needs (including health needs), interests, strengths, preferences and desired outcomes.
- Assist in arranging professional evaluations and other components of the assessment to develop strategies for obtaining the services, resources and supports needed to achieve the recipient's personal outcomes.
- Be knowledgeable of potential community resources, including formal resources (Food Stamps, SSI, housing, etc.).
- Ensure recipient choice.

- Follow up with the recipient on a regular basis but no less than quarterly. At the quarterly face-to-face visit discuss with recipient if all services are appropriate and satisfactory and being delivered as planned or are changes required.
- Assist the recipient to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the approved CPOC.
- Have knowledge of all Medicaid services and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.
- Assist and remove any barriers that the recipient may have in obtaining the identified services.
- Advocate on behalf of the recipient to help establish, expand, maintain and strengthen the natural support network, and obtain appropriate services. This may involve calling and/or visiting recipient, community groups, organizations or agencies with or on behalf of the recipient.
- Inform the recipient no less than quarterly of all Medicaid services for which they maybe eligible.
- Prepare the annual CPOC and appropriate updates and assessments.
- Keep the required documentation in the record as well as in the CMIS.

Note: ***Advocacy is defined as assuring that the recipient receives appropriate services of high quality and locating additional services not readily available in the community.***

Note: ***After the initial CPOC is completed, all billable ongoing case management services must be provided according to the current approved CPOC.***

5.7.5 COMPREHENSIVE PLAN OF CARE

CPOC planning refers to a process whereby an analysis of information from the formal evaluations and the person-centered supports assessment is utilized. The CPOC is developed based on the identified needs and the unique personal outcomes envisioned, defined and prioritized by the recipient.

- The CPOC is developed through a collaborative process involving the recipient, the case manager and others who the recipient request be in attendance.

- The CPOC must be completed in a face-to-face meeting with the recipient.

Required CPOC Procedures

The CPOC meeting must be a face-to-face visit, preferably in the home with the recipient. The CPOC meeting must be held at a time that is convenient for the recipient.

The CPOC must be outcome-oriented, individualized and time limited. Essential elements of the planning process include:

- Tailoring the CPOC to the recipient's needs based on the on-going person-centered assessment.

- Developing mutually agreed upon strategies to achieve or maintain the desired personal outcomes, which rely on informal, natural community supports and appropriate formal paid services.

- Discussion with the recipient about available Medicaid services.

- Assisting the recipient in developing an action plan which will lead to the implementation of strategies to achieve the desired personal outcomes.

- The CPOC must not be completed prior to the CPOC meeting.

- Signatures of all participants are required.

Required CPOC Components

The CPOC must incorporate the following required components:

- The recipient's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes.

- Target/resolution dates for the achievement/maintenance of personal outcomes;

  - Identifying the preferred formal and informal service providers and specifying the service arrangements.

- Provide information to the recipient regarding appropriate Medicaid services.

Required CPOC Time Frames

- The CPOC must be completed and received by BCSS Regional office within thirty-five (35) calendar days from the date of the linkage.

- The CPOC must be revised annually or as necessary to meet the needs of the recipient and must be reflected in the approved revised CPOC and submitted to the BCSS Regional office no later than 35 calendar days prior to expiration.

- Assessments must be done quarterly to ensure that the CPOC continues to address the recipient's needs.

Changes in the CPOC

- If there are significant changes in the way the recipient defines or prioritizes the personal outcomes, or in their formal service needs, the CPOC must be revised.

  Note: The annual date of the CPOC never changes.

5.7.6 BUILDING AND IMPLEMENTING SUPPORTS

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

Note: The HIV-Targeted population is eligible for all Medicaid services, which may be implemented as soon as the need is identified. The CPOC does not have to be approved to implement services.

Responsibilities of the Case Manager

The case manager is responsible for assisting to build and implement the supports and services as described in the approved CPOC. The case manager is responsible for:

- Assisting the recipient to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the approved CPOC.

- Being knowledgeable of potential community resources, including formal resources (Food Stamps, SSI, housing, etc.)

- Being knowledgeable of all Medicaid services and informal/natural resources, that may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.

- Assisting the recipient to initiate, develop and maintain a natural support network and to obtain the services identified in the approved CPOC assuring that they meet the recipient's individual needs.

- Advocate on behalf of the recipient to help establish, expand, maintain and strengthen the natural support network, and obtain appropriate services. This may involve calling and/or visiting recipients, community groups, organizations or agencies with or on behalf of the recipient.

- Assisting the recipient to overcome obstacles, recognizing potential opportunities, and developing creative opportunities.

- Meeting with the recipient in a face-to-face (preferably in the home) visit at least once per quarter and more often if necessary to meet the recipient's needs.

- When preparing quarterly summary, the case manager must indicate the dates of services being discussed. (Actual time period being covered (ex. April 27, 2002 to July 27, 2002).

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

Note: After the initial CPOC is completed, all billable ongoing case management services must be provided according to the current approved CPOC.

5.7.7 MONITORING OF SERVICES

Monitoring of support strategies is not required for this population. The case manager must follow-up with the recipient to see that they are receiving the services described on the approved CPOC and to assist in removing any barriers they may have in obtaining any services.

Note: All contacts shall be entered no less than monthly into CMIS. No billing for the month shall occur until all contacts have been entered into CMIS.

5.7.8 CASE MANAGEMENT TRANSITION AND CLOSURE

The transition or closure of case management services must occur in response to the request of the recipient, or if the recipient is no longer eligible for services as described below. The closure process must ease the transition to other services or care systems.

Closure Criteria

Case management services closure criteria include but are not limited to the following:

- The recipient requests termination of services.
- Death of the recipient.
- Recipient is no longer Medicaid eligible.
- Permanent relocation of the recipient out of the service area.
  The safety of the case manager is in question. The case management agency must contact BCSS Regional office to discuss the situation.
- If an individual is institutionalized, the case manager must contact the BCSS Regional office to discuss the situation. The case manager must provide information as to whether this is a permanent or temporary placement such as the need for rehabilitation services.
- Recipient refuses services and/or refuses to comply with case management and BCSS requirements.
- The case management agency closes (see transfer procedures).
- The recipient no longer meets eligibility requirements for HIV targeted population.

Note: If the recipient refuses to comply with case management requirements, the case manager must document all instances appropriately and contact BCSS Regional Office immediately.

Required Transition/Closure Procedures

- Transition/closure decisions should be reached with the full participation of the recipient. If a recipient becomes ineligible for services, the case manager must notify the recipient and BCSS Regional office immediately.

- The case manager must complete a final written reassessment identifying

any unresolved problems or needs and discuss with the recipient methods of negotiating their own service needs.

- The agency must follow their own policies and procedures regarding intake and closure.

- A case closure/transfer discharge summary must be prepared by the case manager within 14 calendar days of discharge and submitted to the BCSS Regional office.

- The case manager must assure that the receiving agency's program or case manager receives copies of the most current approved CPOC and any revisions to the CPOC and related documents.

Note: A closure report from CMIS must be submitted to BCSS or designee.

5.7.9 PROCEDURES FOR CHANGING CASE MANAGEMENT AGENCIES

A recipient may change case management agencies at any time.

- Once the recipient has selected a new case management agency and has been linked the new agency must complete the FOC file transfer form.

- Upon receipt of the completed form, the transferring case management agency must provide copies of the following information:

  - Most current approved CPOC and any subsequent revisions
  - Current assessments on which CPOC is based
  - Most current 6 months of progress notes

(The 148 must be completed to reflect the date of the transfer of records and submitted to the BCSS Regional office and BCSS or designee.)

- The transferring case management agency shall provide services up to the transfer of records and may bill for services after dated notification is received (transfer of records) by the receiving case management agency. In the month the transfer occurs, the receiving case management agency shall begin services within three working days after the transfer of records and may bill for services the first full month after the transfer of records. The receiving case management agency must submit the required documentation to BCSS or designee to begin

prior authorization immediately after the transfer of records.

5.8 HIGH RISK PREGNANT WOMEN

5.8.1 ELIGIBILITY

The recipient must meet ALL of the following eligibility requirements for this target population to receive high risk pregnancy case management services:

- Pregnancy determined high risk based on the completion of the "DHH Case Management Prenatal High Risk Screening Form", a medical risk screening and written referral from a licensed physician, licensed primary nurse associate, or a certified mid-wife.
- Must require services from both formal and informal multiple health, social service providers and is unable to obtain the necessary services.
- Must reside in one of the following parishes: Orleans, Jefferson, St. Charles, St. John, or St. Tammany.
- Must obtain Prior Authorization to bill within 60 days of the referral.

5.8.2 INTAKE

Intake for High-Risk Pregnant Women must include:

- Completing the DHH High Risk Screening Form by licensed physician, licensed primary nurse associate or certified midwife.
- Risk screening must be completed prior to agency accepting recipient for services.
- The intake interview must include the following:
  - A thorough explanation of the program and a description of services available.
  - Review of medical emergency procedures and telephone numbers.
  - A review of delivery plans and infant care plans and access to needed medical services.

- An identification and discussion of immediate needs and concerns of the recipient.
- A written appointment for clinic or medical services provided to the recipient.
- A scheduled CPOC for the psycho-social and nutritional assessments.
- The obstetrical provider and the case management provider must have written agreement to share information regarding the recipient's medical compliance and other pertinent information.

5.8.3 ASSESSMENT

An assessment of high risk pregnant women is a professional evaluation of the high risk patient to identify factors that may adversely affect their health status.

- A home assessment is as required part of the case manager's initial assessment. This will enable the case manager and multi-disciplinary team to identify needs in the home environment and allow a comprehensive assessment.
  - The assessment must be completed during the initial month of services.
  - Part I of the "High Risk Pregnant Women Case Management Assessment Form" must be completed by the case manager during the initial home visit.
- Other Required Assessments
  - In addition to the home visit, a social, nutritional, and medical assessments are required components of the comprehensive assessment to identify the needs for counseling, intervention, and follow-up services. These assessments assist each discipline with developing specific strategies for counseling and intervention to promote the best possible outcome for the high risk maternity patient.
    - Each discipline evaluates the recipient and family needs through interactions and interviews.
    - Assessment must identify areas for counseling, intervention and follow up services.

- The social and nutritional assessment must be documented on the "High Risk Pregnant Women Case Management Assessment Form".

- The medical assessment must be documented on a standardized form approved by the American College of Obstetricians and Gynecologists (ACOG) or DHH Office of Public Health and must be properly signed and dated by the obstetrical provider.

- The required medical, social worker, and nutritionist assessments provide the case manager with a method to prioritize and coordinate the multi-disciplinary team's approach.

  It is necessary to have thorough professional assessments in order to develop a relevant CPOC.

  Note: These professional assessments are not covered case management services.

Time Limits and Setting

Assessments must be completed within fourteen (14) calendar days after the prenatal case management risk assessment is completed. There may be extenuating circumstances that hinder compliance with this time frame for the assessment. Extenuating circumstances are unexpected events beyond the control of the case manager such as:

- Inability to contact the recipient

- Medical emergency or hospitalization

- Recipient is not available for home visits when scheduled or attempted

- Recipient has relocated without notifying the case manager of a new address or telephone number. Failure to comply with this time frame must be clearly documented in the case management record. If the situation cannot be corrected within twenty-one (21) calendar days from the date of intake screening, the case must be evaluated or staffed for closure.

5.8.4 DEVELOPMENT OF THE COMPREHENSIVE PLAN OF CARE

The CPOC for high risk pregnant women must be developed through a ***multi-disciplinary team staffing***.

- All assessments must be completed prior to scheduling the staffing.
- The CPOC staffing must be completed within 30 calendar days of the prenatal risk assessment.
- The recipient may be restaffed one time during the pregnancy or post-partum period or as necessary to maintain a viable comprehensive plan of care.
- The multi-disciplinary team staffing must be attended by the recipient, whenever possible, case manager, a licensed obstetrical provider (physician, certified primary nurse associate or certified nurse midwife with obstetrical experience), registered nurse; licensed social worker or Master's level social worker under the supervision of a licensed social worker, and registered dietician.
- The development of the CPOC must include:
  - Direction and leadership by the case manager;
  - Presentations of professional assessments and recommendations;
  - Prioritization of the service objectives and interventions to address those areas that most significantly affect the health status of the recipient.

5.8.5 MONITORING OF SERVICES

- At a minimum, monthly verbal contacts must be made with the recipient's obstetrical provider.
- Weekly face-to-face or telephone contacts must be made with the recipient, service providers and/or informal supports in addition to monthly face-to-face visits and quarterly home visits with the recipient to implement the CPOC and follow up/monitoring service provision and the recipient's progress in accordance with the CPOC. A weekly contact with the recipient is required beginning with her 37th week of pregnancy until delivery.

- A postpartum home visit must be made within 10-14 calendar days after delivery focusing on postpartum concerns and the care of the infant.

- The case record must have documentation and results of the monitoring

5.8.6 TRANSITION/CLOSURE CRITERIA

All case management services to high risk pregnant women must be terminated no later than sixty (60) days from the date of delivery or miscarriage.

SECTION 6
STAFFING REQUIREMENTS

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6.0 INTRODUCTION

The Department of Health and Hospitals has the responsibility to establish reasonable qualifications for providers to ensure that they are capable of providing case management 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 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 case management services.

6.1 CASE MANAGEMENT REQUIREMENTS

Each DHH contract case management regional provider must have an on-site project manager, nurse consultant, 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 another medicaid funded service to the recipient
- If an exception has been given by the BCSS Case Management Administrator for irreconcilable differences.

Non-contract case management providers are not required to have an on-site program manager or a nurse consultant. 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 provider 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. Failure to comply with these regulations may result in any of the following: recoupment, sanctions, and/or loss of enrollment or licensure.

6.1.1 EDUCATION AND EXPERIENCE

On-Site Project Managers are responsible for the overall operation of the agency and are responsible to 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 who work with children (0-18 years of age) must obtain a criminal history records check and it must be kept in their personnel file. 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 full-time 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

  - 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.

- 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.

- Additional qualifications for specific targeted or waiver populations are described below.

  - High Risk Pregnant Women

    Each case management agency must ensure that each case manager providing case management services to high risk pregnant women meets the education and experience identified above and also have the following qualifications:

    - Demonstrated knowledge about perinatal care with formal health training that includes, but is not limited to the following areas:

      - Impact of over-the-counter and prescription drugs, and any other chemical substances and their impact on the fetus.
      - Importance of prenatal visits.
      - Signs of pre-term.
      - Procedures for hospitalization.
      - Chronological age of mother and its impact on fetus size.
      - Development of the fetus.
      - Impact of nutrition on the fetus, etc.

OR

    - A registered dietician;

AND

  - One (1) year of full time paid experience in providing nutrition services to pregnant women.

  - Nurse Home Visits For First Time Mothers

    Prior to providing services each case management agency must ensure that each case manager providing case management services to first time

mothers meets the education and experience listed below:

- Be a registered nurse in possession of a license or temporary permit to practice professional nursing in the State of Louisiana; and

- Have certification of training in the David Olds Prenatal and Early Childhood Nurses Home Visit Model

Case Manager Trainee

All requests for this position must be submitted in writing to the BCSS Case Management Administrator from the Onsite Project Manager and must state the following:

- That the employee meets the educational requirements;
- The name of the supervisor;
- That the supervisor's caseload has been adjusted to include this position as one of the (eight) 8 supervisees allowed and that only (one) 1 trainee will be assigned to any (one) 1 supervisor;
- A statement ensuring that the trainee will receive the required supervision and training;
- A copy of the Individual Employee Supervision Plan;
- A prospective date of hire, and
- A copy of the written approval letter from the BCSS Case Management Program Manager must be maintained in the personnel file. No Exceptions

NOTE: ***There will be no retroactive approval nor payment made for any case management activity performed by the case manager trainee prior to the written date of approval from the BCSS.***

Qualifications

The case manager trainee must meet all of the educational requirements of a case manager.

The experience will be waived with the addition of increased supervision and a limited caseload.

The case management trainee must meet the following educational qualifications:

- A bachelor's degree in social work, or
- A bachelor's degree in psychology, or
- A bachelor's degree in education rehabilitation counseling, or
- A bachelor's degree in a human-service-related field from an accredited college

or university.

Caseload

A case manager trainee's caseload may never exceed 20 recipients.
The population makeup of the caseload may include the following populations:

- Infants and Toddlers
- HIV
- MR/DD Waiver
- Elderly and Disabled Adults
- EPSDT
- Children's Choice

Duties/Responsibilities

The case manager trainee will participate in the following duties with the direction of veteran case management staff and the case management supervisor based on the Individual Employee Supervision Plan (IESP):

- Participate in the initial interview with the recipient/family.
- Joint assessment with a case manager of the recipient's need for immediate case management.
- Participate in the development of the recipient's CPOC/IFSP.
- Review with the case manager all the necessary releases, consents and rights in order to understand the purpose/use of the material.
- Participate in monitoring the recipient's CPOC/IFSP, including the monitoring of service provision.
- Learn and demonstrate the ability to gather and summarize recipient specific information (social summary/evaluation).
- Gain knowledge and experience in community resources and resource development, and use of resources/natural supports.
- Actively participate in supervision with the case management supervisor as described in their Individual Employee Supervision Plan.
- Actively participate in all agency trainings and staffings as identified by the case management supervisor.
- The trainee must sign all documents as "Case Manager Trainee".

NOTE: The Case Manager Trainee shall not perform duties that are clerical in nature to support other case management staff.

Supervision

The trainee position counts as one (1) of the eight (8) case managers under a supervisor's direction. There shall only be one (1) case manager trainee position per supervisor.

The supervisor is accountable for the training, experience and activities of the case manager trainee and will be responsible to develop and implement an Individual Employee Supervision Plan (IESP) that will designate the training, field experience, and peer relationships for the trainee for a period of no less than (1) year. The supervision is more intense for these positions and includes the following:

- Supervise the trainee on a daily basis for a period of three months.
- After the three months, an assessment shall be completed to identify areas on which to focus training and supervision. If all areas are covered in the first 3-month period, supervision may begin occurring less frequently, but no less than 3 times per week for the remainder of the year of training.
- The case management supervisor shall conduct regular field visits with the trainee to view the trainee's application of case management knowledge and skills. The number of visits the supervisor attends shall be no less than 1/3 of the trainee's caseload. A veteran case manager may attend the other visits, but in no instance shall the trainee make visits alone.
- The supervisor shall sign all case record documentation and CPOC's for the trainee.
- At the end of the year, the case manager supervisor must submit a letter to the BCSS Case Management Administrator requesting change of status from case manager trainee to case manager. The case manager supervisor must verify completion and outcome of the IESP.

Training

In addition to the training for case managers (initial and annual) outlined in this manual, the trainee is required to have at least an additional 40 hours of training (general supervision excluded). The trainee must attend a basic Case Management Training within 45 days of hire which will be counted toward the additional 40 hours. The request for the training shall come from the agency/supervisor to the BCSS Case Management Administrator no later than 5 days after the hire date.

Case Management Supervisor or any Other Individual Supervising Case Managers

All case management supervisors must meet the qualifications for education and experience listed below. This includes supervisors for High Risk Pregnant Women, EPSDT, MR/DD Waiver, Infants and Toddlers, Children's Choice, HIV, and Elderly and Adult Disabled.

- 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 paid full-time 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 at least one of the target or waiver populations to be served;

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 paid full-time 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) years of this experience must be in providing direct services to at least one of the target or waiver populations to be served;

OR

- A licensed registered nurse;

AND

Three (3) years of paid full-time 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 at least one of the target or waiver populations to be served;

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

Three (3) years of paid full-time 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 at least one of the target or waiver populations to be served;

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 paid full-time 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 at least one of the targeted or waiver populations to be served. 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.***

Nurse Consultant

Case management agencies must employ or contract with a nurse to provide consultation on health related issues and education and training to the agency's staff and supervisors. He/she must be employed or contracted for a minimum of 4 hours per week and should be on site at the agency.

The agency shall have a written job description and consultation plan describing how the nurse will participate in developing the CPOC for medically complex individuals and others with high risk indicators.

All nurse consultants must meet the following minimum qualifications for education and experience:

- A Louisiana registered nurse with a bachelor's degree in nursing and one year of paid experience as a registered nurse in a public health or human service field providing direct recipient services or case management. No substitutions for the bachelors degree in nursing will be allowed.

High Risk Pregnant Women

Each Medicaid enrolled provider must ensure that all case management supervisory staff for high risk pregnant women have demonstrated knowledge of perinatal care with formal training that meets the qualifications in the supervisor's education and experience section:

- 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 the target population to be served;

  AND

  Demonstrated knowledge about perinatal care;

  OR

- A licensed registered nurse;

  AND

  Three (3) years of full-time paid post-Bachelor's 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 the target population to be served;

  AND

Demonstrated knowledge about perinatal care;

OR

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

AND

Two (2) 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. One (1) year of this experience must be in providing direct services to the target population to be served;

AND

Demonstrated knowledge about perinatal care;

OR

- A registered dietician;

AND

Three (3) 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 pregnant women.

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.

Nurse Home Visits For First Time Mothers

Each Medicaid enrolled provider must ensure that all case management staff and supervisors for the Nurse Home Visitation Program have the required certification of training in the David Olds Prenatal and Early Childhood Nurses Home Visit Model prior to performing the assigned duties.

- Supervisor

- The case manager supervisor must have one year of professional nursing experience in addition to the above referenced case manager qualifications. A master's degree in nursing or public health may be substituted for the required one year of professional nursing experience for the supervisor.

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 provider 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 service plans
  - Coordinating delivery of 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 service 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. Outside agency training record entries should be supported by training attendance certificates which have all the required components for documentation. If no training attendance certificates were issued, then agency's supervisor should sign the record entry form. Internal agency training documentation should have all components in the record entries or on agency certificates. A supervisor or On-site manager's signature should be on the agency training record or the agency's certificate. All internal agency training should be supported by a staff signature sheet which has the required documentation. All training records should have an on-going balance of accrued training hours.

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 the target population including, but not limited to, specific 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 the target or waiver populations
- Professional ethics
- 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 the target or waiver populations to be served and specific knowledge, skills, and techniques necessary to provide case management to the target or waiver populations.

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

  - This training must include the following at a minimum:

    - Assessment techniques
    - Support and service planning
    - Support and service planning for people with complex medical needs, including information on bowel management, aspiration, decubitus, nutrition
    - 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. Case manager's annual training year begins with the date of hire.

- 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 services for the population
  - Building natural support systems
  - Family dynamics
  - Developmental life stages
  - Crisis management
  - First aid/CPR
  - Signs and symptoms of mental illness, alcohol and drug addiction, mental retardation/developmental disabilities and head injuries
  - Recognition of illegal substances
  - Monitoring techniques
  - Advocacy
  - Behavior management techniques
  - Values clarification/goals and objectives
  - Available community resources
  - Accessing special education services
  - Cultural diversity
  - Pregnancy and prenatal care
  - Health management
  - Team building/interagency collaboration
  - Transition/closure
  - Age and condition-appropriate preventive health care
  - Facilitating team meetings
  - Computers
  - Stress and time management
  - Legal issues
  - Outcome measures
  - Person-centered planning
  - Self-determination or recipient-directed services

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

Training-Infants and Toddlers with Special Needs

Ongoing annual training is the responsibility of the family service coordination agency.

- Family Service Coordination Staff

  A minimum of eight (8) hours of orientation for new family service coordination staff must be ChildNet specific training as defined by the Department of Education (DOE).

  - A minimum of twenty-four (24) additional hours of training must be provided to new family service coordinators in the first ninety (90) calendar days of employment. This training must cover advanced subjects as defined by the DOE in addition to the subjects listed above.

  - Initial training specific to ChildNet must be arranged and/or coordinated by the Regional Infant/Toddler Coordinator. Specific ChildNet training content must be approved by a sub-committee of the State Interagency Coordinating Council.

  - Advanced training in specific subjects must be satisfactorily completed prior to the case manager/family service coordinator assuming those duties.

- Family Service Coordination Supervisor

- Each new family service coordination supervisor must satisfactorily complete a minimum of 40 hours of family service coordination training before assuming supervisory duties for this target population.

- Each experienced supervisor must also complete a minimum of forty (40) hours per calendar year including advanced ChildNet specific subjects defined by DOE.

Documentation of all training required must be maintained in the employee personnel record and provided to DHH upon request.

Mandatory DHH Case Management Training

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

Case Management Contractors

Case Management Contracts have additional requirements in addition to the requirements contained in Section 6, Pages 6-14 to 6-18. Contractors must:

- Submit within 30 days of the contract signing for BCSS approval an agency training plan that reflects at a minimum orientation to the agency's Quality Assurance (QA) process and expectations.

- Assure appropriate staff attend regularly scheduled training meetings with BCSS staff or designees.

- Submit 45 days before the end of the contract year for BCSS approval an annual training plan developed using information from agency self-evaluations and BCSS monitoring of the agency.

- Assure staff participate in technical assistance and training provided in the area of personal outcome measures.

- Designate an employee who will be responsible for coordination of competency-based training and documentation of training as it relates to the QA/QI plan of

the agency and self-improvement plan of the employee.

- Provide training to assure that all staff will have a working knowledge of supports/resources that allow for implementation of best practices in case management/service coordination including, but not limited to, those that reflect personal freedoms and rights of recipients.

CASE MANAGEMENT STAFF COVERAGE

All staff and caseload information shall be continually 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 pagers at all times when not on site.

- A Case Management agency is required to have nurse consultation available through direct employment or contract, during regular business hours for no less than four (4) hours per week.

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

Nurse Consultation

Each contracted case management agency must have a written job description and consultation plan that describes how the nurse consultant will participate in CPOC development for medically complex individuals and others as indicated by high risk indicators. The nurse should provide consultation to the case management agency staff on health related issues as well as education and training for case managers and case manager supervisors.

SUPERVISION

Each case management agency, regardless of population served, 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. The year to be evaluated begins with the case manager's date of hire.

- 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 includes the following:

  - 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.

- 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: Maximum Number of Staff and Caseload Mix

  - Each 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 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 qualifications in this section.

  - The case management agency must submit a written plan for approval by the BCSS Case Management Administrator. The plan must detail how supervision and case management functions will be performed by the same person. The plan must be approved by the BCSS Case

Management Administrator prior to implementation.

- Case Manager: Maximum Caseload Size

  - Each full-time case manager can have a caseload of no more than thirty-five (35) recipients regardless of target or waiver populations.

  - The caseload mix and size must be monitored by the supervisor to ensure that the case manager can adequately manage and provide quality services to the recipients with whom they work.

Part-Time Case Managers

A part-time case manager may be used for a 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 qualifications for a case manager. All requests must be approved by the BCSS Case Management Administrator. Requests for approval will be monitored for frequency of request and must contain the following information:

- Name of the supervisor;

- An assurance that the agency's supervisory personnel will respond in a timely manner during the 40 hour work week and who will be responsible for emergencies that may arise after normal business hours;

- A signed statement by the part-time case manager that they have no other job;

- A monitoring plan to assure the person's availability and response time to the recipient;

- Plans must be signed by the agency's contract administrator (name on the Board Resolution)

Request for part-time case managers received after date of hire will be approved effective the date of request. Email requests will be accepted but require a follow-up from the case management agency in writing with all required information.

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 Assurance and similar 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 agency's caseload. All plans must be approved by the BCSS Case Management Administrator prior to implementation. These are temporary plans only.

- Sharing Onsite Project Managers

  Agencies having more than one contract where project managers share administrative responsibilities must re-submit a plan to the BCSS Case Management Administrator. This plan must be approved prior to its implementation. The plan's approval is completely at the discretion of the BCSS Case Management 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 project managers will be in each office and how they will maintain contact.

SECTION 7
FINANCIAL REQUIREMENTS/REIMBURSEMENTS

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7.0 PRIOR AUTHORIZATION

All case management services must be prior authorized before billing for services. Claims can not be submitted until the billing cycle is completed and all data is entered into Case Management Information Systems (CMIS), the required data system. A Prior Authorization (PA) number cannot be used for billing if the recipient is not Medicaid eligible. If BCSS or designee issues a PA number that begins prior to the date on which the recipient becomes Medicaid eligible, that PA number can not be used to bill.

Case management agencies must submit data for the statewide data base to obtain a PA number. The required time lines for submission are no less than weekly. After case management services are entered into CMIS, PAs for the first two months of the quarter will be released, however if services are not entered into CMIS which document the provision of the required services, PAs for the last month of the quarter will not be released. The month that a recipient's case is closed becomes the last month of the quarter and all quarterly required services must be completed. BCSS Quality Management personnel will monitor case management records to determine if documentation in the case manager records supports CMIS entries. If documentation to support CMIS entries is not found in the case manger records, recoupment will be made. Referral to SURS may be made since this is viewed as intentional misrepresentation of services provided. Information files must be submitted to BCSS or designee via e-mail.

7.0.1 MR/DD CASE MANAGEMENT

Procedure Code (Z0182) is to be used for MR/DD Case Management. The procedures for issuing Prior Authorization (PA) numbers for MR/DD 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 BCSS or designee. BCSS or designee receives the FOC form from the recipient.

- BCSS or designee will link recipients to their first choice, if the case management agency has not reached their capacity. In the event that capacity is reached, recipients will be assigned to their second choice in a three-agency region and to the second agency in a two-agency region. Recipients will be assigned on a first received, first assigned basis.

- BCSS or designee notifies the linked case management agency of a new MR/DD recipient by mailing the case management agency the FOC form with a workday journal. BCSS or designee also notifies the recipient of the assigned agency. Only linkages from BCSS or designee are valid.

- The case management agency mails the **approval page of the CPOC** so that it is received by BCSS or designee no more than 60 days from the CPOC meeting date. This page will not be accepted by telephone or fax.

- The PA number is issued with an effective starting date no earlier than the later of the following:

  - The PA period will start 35 days prior to the BCSS Regional Office packet receipt date as indicated/stamped on the CPOC approval page but not before the CPOC signature date, or the freedom of choice date.

  OR

  - No more than 60 days prior to the BCSS or designee packet receipt date requesting a PA number.

  The PA period will end one month after the end of a fiscal quarter, either January 31, April 30, July 31, or October 31.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to BCSS or designee on the Replacement PA form. Requests will not be accepted by telephone.

Renewal PAs

BCSS or designee will automatically issue PA numbers for MR/DD Waiver recipients beginning the first day of the month after the current PA period ends. Renewals will be for a 6 month period.

Transfer of Recipient

- FOC forms for case management are provided by mail to the recipient only by BCSS or designee. BCSS or designee receives the FOC form from the recipient.

- BCSS or designee will notify the linked case management agency of a new recipient by mailing the agency the FOC form indicating the transferring agency with a cover letter or linkage report. BCSS or designee will also notify the recipient of the assigned agency. Only linkages from BCSS or designee are valid.

- The receiving case management agency must contact the transferring case management agency to obtain the required records. Both the transferring and receiving agencies complete the Transfer of Records Section on the FOC 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**. The receiving agency mails the completed FOC form/Transfer of Records Section to BCSS or designee. The FOC form/Transfer of Records Section will not be accepted by telephone or fax.

- A new PA number 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 BCSS or designee backdate the PA period prior to the first day of the month in which the FOC form/Transfer of Records Section is received by BCSS or designee. The transferring agency's PA number will expire on the date of transfer of records.

NOTE: ***Lack of cooperation in the transfer of records process must be reported to the BCSS Help Line at 1-800-660-0488. All allegations of failure to cooperate will be reviewed by the BCSS Case Management Program Administrator.***

Case Closure

The case management agency is required to submit the Form 148 with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Case management agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

Group Home Conversion or Developmental Center Discharges

BCSS will approve payment for up to 4 months prior to the discharge date from a Developmental Center or Group Home Conversion. In order to receive the PA number for this time period you must include the Form 148 (with the reason for discharge noted) from the discharging agency and all progress notes for the 4 month time period prior to discharge in addition to the Approval Page of the CPOC when requesting a PA number. These requests will be forwarded to BCSS State Office for the Case Management Administrator's approval.

7.0.2 EPSDT - TARGET POPULATION RECIPIENTS

Procedure Code Z0309 is to be used for EPSDT Target Population Recipients. The procedures for issuing PA numbers for the EPSDT Target Population recipients are as follows:

New Case Management Recipients

- FOC forms for case management are provided to the recipient only by BCSS or designee. BCSS or designee receives the FOC form from the recipient.

- BCSS or designee will link recipients to their first choice if the case management agency has not reached their capacity. In the event that capacity is reached, recipients will be assigned to their second choice in a three-agency region and to the second agency in a two-agency region. Recipients will be assigned on a first received, first assigned basis.

- BCSS or designee notifies the linked case management agency of a new EPSDT recipient by mailing the agency the FOC form with a workday journal. BCSS or designee also notifies the recipient of the assigned agency. Only linkages from BCSS or designee are valid.

- The case management agency mails the **approval page of the CPOC** so that it is received by BCSS or designee no more than 60 days from the CPOC meeting date. This page will not be accepted by telephone or fax.

- The PA number is issued with an effective starting date no earlier than the later of the following:

- The PA period will start 35 days prior to the BCSS Regional Office packet receipt date as indicated/stamped on the CPOC approval page but not before the CPOC signature date, or the Freedom of Choice Date.

- No more than 60 days prior to the BCSS or designee packet receipt date requesting a PA number.

The PA period will end one month after the end of a fiscal quarter, either January 31, April 30, July 31, or October 31.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to BCSS or designee on the Replacement PA form. Requests will not be accepted by telephone.

Renewal PAs

BCSS or designee will automatically issue PA numbers for EPSDT Target Population recipients beginning the first day of the month after the current PA period ends. Renewals will be for a 6 month period.

Transfer of Recipient

- FOC forms for case management are provided to the recipient only by BCSS or designee. BCSS or designee receives the FOC form from the recipient.

- BCSS or designee will notify the linked case management agency of a new recipient by mailing the agency the FOC form indicating the transferring agency with a cover letter or linkage report. BCSS or designee will also notify the recipient of the assigned agency. Only linkages from BCSS or designee are valid.

- The receiving case management agency must contact the transferring agency to obtain the required records. Both the transferring and receiving agencies complete the Transfer of Records Section on the FOC 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. The receiving

agency mails the completed FOC form/Transfer of Records Section to BCSS or designee. The FOC form/Transfer of Records Section will not be accepted by telephone or fax.

- A new PA number 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 BCSS or designee backdate the PA period prior to the first day of the month in which the FOC form/Transfer of Records Section is received by BCSS or designee. The transferring agency's PA number will expire on the date of transfer of records.

NOTE: ***Lack of cooperation in the transfer of records process must be reported to the BCSS Help Line at 1-800-660-0488. All allegations of failure to cooperate will be reviewed by the BCSS Case Management Program Administrator.***

Case Closure

The case management agency is required to submit the Form 148 with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Case management agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

Recipient Re-Entering Case Management Program

If a recipient reenters the case management program within 6-months of the original linkage date and the case has been closed, the agency will submit the EPSDT Recipient Re-entering Case Management Program form. The PA period will begin on the date the recipient re-enters the program but no earlier than 60 days prior to receipt of form by BCSS or designee.

7.0.3 CHILDREN'S CHOICE CASE MANAGEMENT

Procedure Code 9E001 is to be used for Children's Choice (CC) case management. The procedures for issuing PA numbers for Children's Choice Case Management recipients are as follows:

New Case Management Recipients

- FOC forms for case management are provided to the recipient by BCSS or designee. BCSS or designee receives the FOC form from the recipient.

- BCSS or designee links the recipient to their choice of case management agency, depending on availability. If the recipient is an EPSDT target population recipient currently linked as receiving EPSDT target population (ETP) case management and wishes to remain with the same agency, they may remain with the same agency and will be dually linked with a target type of CC. If the recipient is not currently linked as target type-ETP, BCSS or designee will link the recipient for EPSDT target population case management with a target type-CCTR (Children's Choice Transition Recipient).

- BCSS or designee notifies the linked case management agency of a new Children's Choice recipient by mailing the agency the FOC form with a workday journal. BCSS or designee also notifies the recipient of the assigned agency. Only linkages from BCSS or designee are valid.

- The BCSS Regional office will mail or fax the demographic cover page, approval page of the CPOC, budget page and the 51 NH to BCSS or designee. The PA for case management providers will begin on the date BCSS issues the 51NH.

- For an existing ETP recipient (target-ETP), the ETP PA will be canceled on the last day of the following month. The Children's Choice PA number (target type-CC) is issued with an effective starting date of the first day of the month after the CPOC approval date and will not overlap with the ETP PA number.

  For a recipient who is linked as Target-CCTR, a PA number is issued starting on the linkage date until the last day of the month.

  - The PA period will start 35 days prior to the BCSS Regional Office packet receipt date as indicated/stamped on the CPOC approval page but not before the CPOC signature date or the Freedom of Choice Date.

  OR

  - No more than 60 days prior to the BCSS or designee packet receipt date requesting a PA number.

  The PA period will end one month after the end of a fiscal quarter, either January 31, April 30, July 31, or October 31.

PA numbers for case management services will be released for billing when billing requirements are met as determined by data submitted by the case management agency in CMIS.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to BCSS or designee on the Replacement PA form. Requests will not be accepted by telephone.

Renewal PAs

BCSS or designee will automatically issue PA numbers for Children's Choice waiver recipients beginning the first day of the month after the current PA period ends. Renewals will be for a 6 month period.

Transfer of Recipient

- FOC forms for case management are provided to the recipient only by BCSS or designee. BCSS or designee receives the FOC form from the recipient.

- BCSS or designee will notify the linked case management agency of a new recipient by mailing the agency the FOC form indicating the transferring agency attached to the workday journal. BCSS or designee will also notify the recipient of the assigned agency. Only linkages from BCSS or designee are valid.

- The receiving case management agency must contact the transferring agency to obtain the required records. Both the transferring and receiving agencies complete the Transfer of Records Section on the FOC 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. The receiving agency mails the completed FOC form/Transfer of Records Section to BCSS or designee. The FOC form/Transfer of Records Section will not be accepted by telephone or fax.

- A new PA number 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 BCSS

or designee backdate the PA period prior to the first day of the month in which the FOC form/Transfer of Records Section is received by BCSS or designee. The transferring agency's PA number will expire on the date of transfer of records.

NOTE: ***Lack of cooperation in the transfer of records process must be reported to the BCSS Help Line at 1-800-660-0488. All allegations of failure to cooperate will be reviewed by the BCSS Case Management Program Administrator.***

Case Closure

The case management agency is required to submit the Form 148 with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Case management agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

7.0.4 ELDERLY AND DISABLED ADULT WAIVER RECIPIENTS

Procedure Code Z0195 is to be used for Elderly and Disabled Adult Waiver recipients. The procedures for issuing PA numbers for the Elderly and Disabled Adult Waiver recipients are as follows:

New Elderly and Disabled Adult Waiver Recipients

- FOC forms for case management are provided to the recipient only by BCSS or designee. BCSS or designee receives the FOC form from the recipient.
- BCSS or designee links the recipient to their choice of case management agency.
- BCSS or designee notifies the linked case management agency of a new recipient by mailing the agency the FOC form with a workday journal. Only linkages from BCSS or designee are valid.
- BCSS Regional office will mail or fax the demographic cover page, approval page of the CPOC, budget page, and the 51 NH to BCSS or designee.

- The PA number is issued with an effective starting date on the 51NH. The PA period will end one month after the end of a fiscal quarter, either January 31, April 30, July 31, or October 31.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to BCSS or designee on the Replacement PA form. Requests will not be accepted by telephone.

Renewal PAs

BCSS or designee will automatically issue PA numbers for Elderly and Disabled Adult Waiver recipients beginning the first day of the month after the current PA period ends. Renewals will be for a 6 month period.

Transfer of Recipient

- FOC forms for case management are provided to the recipient only by the BCSS or designee. BCSS or designee receives the FOC form from the recipient.

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

- The receiving case management agency must contact the transferring agency to obtain the required records. Both the transferring and receiving agencies complete the Transfer of Records Section on the FOC 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**. The receiving agency mails the completed FOC form/Transfer of Records Section to BCSS or designee. The FOC form/Transfer of Records Section will not be accepted by telephone or fax.

- A new PA number 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 BCSS

or designee backdate the PA prior to the first day of the month in which the FOC form/Transfer of Records Section is received by BCSS or designee. The transferring agency's PA number will expire on the date of transfer of records.

NOTE: ***Lack of cooperation in the transfer of records process must be reported to the BCSS Help Line at 1-800-660-0488. All allegations of failure to cooperate will be reviewed by the BCSS Case Management Program Administrator.***

Case Closure

The case management agency is required to submit the Form 148 with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Case management agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

7.0.5 HIV-TARGET POPULATION RECIPIENTS

Procedure Code Z0196 is to be used for HIV target population recipients. The procedures for issuing PA numbers for the HIV-Target Population recipients are as follows:

New HIV Target Population Recipients

- FOC forms for case management are provided to the recipient by the case manager. BCSS or designee receives the FOC form from the recipient or case manager.
- BCSS or designee will link recipients to their choice of case management agency.
- BCSS or designee notifies the linked case management agency of a new recipient by mailing the agency the FOC form with a workday journal. Only linkages from BCSS or designee are valid.
- The case management agency mails the FOC Form along with the signature page of the CPOC to BCSS or designee no more than 60 days from the beginning of the CPOC meeting date. The packet will not be accepted by telephone or fax.

- The PA number is issued with an effective starting date as the approval date listed on the Signature Page with the following exception:

  - If the PA Packet is received by BCSS or designee more than 60 days from the CPOC meeting date, the PA number will be issued with an effective starting date of 60 days prior to the receipt date.

  The PA period will end one month after the end of a fiscal quarter, either January 31, April 30, July 31, or October 31.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to BCSS or designee on the Replacement PA form. Requests will not be accepted by telephone.

Renewal PAs

BCSS or designee will automatically issue PA numbers for HIV target population recipients beginning the first day of the month after the current PA period ends.

Case Closure

The case management agency is required to submit in writing, as well as in CMIS and the Form 148 with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Case management agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

7.0.6 INFANT AND TODDLER WITH SPECIAL NEEDS CASE MANAGEMENT

Procedure Code Z0199 is to be used for Infant and Toddler With Special Needs (ITSN) Case Management. The procedures for issuing PA numbers for ITSN Case Management recipients are as follows:

New ITSN Case Management Recipients

- The case management agency mails the FOC form, CN9A **and** CN9B **or** MDE can be accepted in its place, CN1, Signature page of the IFSP (which includes

the service schedule completed for other Medicaid services the recipient is to receive.)

- The PA number is issued with an effective starting date as the IFSP meeting date listed on the IFSP with the following exceptions:

  - If the packet is received by BCSS or designee more than 60 days from the IFSP meeting date, the PA number will be issued with an effective starting date of 60 days prior to the receipt date.

  The PA period will end one month after the end of a fiscal quarter, either January 31, April 30, July 31, or October 31 or the day prior to the child's third birthday.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to BCSS or designee on the Replacement PA form. Requests will not be accepted by telephone.

Renewal PAs

BCSS or designee will automatically issue PA numbers for ITSN recipients beginning the first day of the month after the current PA period ends.

Transfer Of Recipient

The case management agency mails the FOC, CN9A **and** CN9B **or** MDE can be accepted in its place, CN1, Signature page of the IFSP (which includes the service schedule completed for other Medicaid services the recipient is to receive).

A new PA number will be issued with an effective starting date of the first day of the first month after the date of IFSP, but in no case will BCSS or designee backdate the PA period prior to the first day of the month in which the IFSP is received by BCSS or designee. The transferring agency's PA number will expire on the last date of the month that the new IFSP was completed.

*NOTE: **Lack of cooperation in the transfer of records process must be reported to the BCSS Help Line at 1-800-660-0488. All allegations of failure to cooperate will be reviewed by the BCSS Case Management Program Administrator.***

Recipient That Goes On And Off Medicaid

The case management agency will submit the required form to indicate that a recipient has become Medicaid eligible and is requesting a PA number.

Case Closure

The case management agency is required to submit in writing, as well as in CMIS and the Form 148 with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Case management agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

7.0.7 NURSE HOME VISITS FOR FIRST TIME MOTHERS

Procedure Codes Z0305-Mother, and Z0307-Child is to be used for Nurse Home Visits for First Time Mothers (NHVFTM). The procedures for issuing PA numbers for Nurse Home Visits for First Time Mothers recipients are as follows:

New Recipients

- MOTHER

  Signed FOC form. The expected date of birth must be included on the FOC form.

- CHILD

  Recipient data form with Medicaid number written on the top right corner. Signature page of the approved CPOC.

Transfer Of Recipients

If a recipient is transferring from one region to another region:

- MOTHER

  Signed FOC form. The expected date of birth and the region where the recipient is moving from must be included on the form.

- CHILD

Recipient data form with Medicaid Number written on the top right corner. The region from which the recipient is moving must be included on the form.

NOTE: Lack of cooperation in the transfer of records process must be reported to the BCSS Help Line at 1-800-660-0488. All allegations of failure to cooperate will be reviewed by the BCSS Case Management Program Administrator.

Issuance Of Prior Authorization Numbers

Prior authorization numbers will be issued on a monthly basis. BCSS or designee will run reports from the CMIS Data System on the 15th of the month for the previous month. PA numbers will be issued based on all service requirements being met. PA numbers will be mailed to the case management agency's office.

Replacement PAs

Replacement PA numbers required because of incorrect Medicaid numbers will be issued for the exact date range of the original PA number. A request for a replacement PA number must be sent in writing to BCSS or designee on the Replacement PA form. Requests will not be accepted by telephone.

Disputing PAs

If a case management agency is not issued a PA number for a recipient and wishes to dispute the non-issuance of a PA number, the case management agency must submit a copy of the NHVFTM Required Action report for that recipient and the reason that the agency is requesting the PA request be reviewed. These requests will be submitted to BCSS State Office Case Management Administrator for review.

Case Closure

The case management agency is required to submit the signed closure from the CMIS software Closure form with the reason for closure noted. The PA time period will be modified to end on the date of closure. BCSS or designee will send the modified PA on the workday journal. Case management agencies must edit/modify the PA record in the CMIS software to reflect the modified PA.

7.0.8 IMPORTANT THINGS TO REMEMBER

Recipient Mailing Address

All addresses must be kept up-to-date in the CMIS software. BCSS or designee use CMIS data when sending mail outs to the recipients.

Site Information

Edit/Modify site information in the CMIS software when there are changes. BCSS or designee use this data for contacting the case management agency.

PA Request

Case management agencies should receive a PA number within 7 days of sending the request to BCSS or designee. If the case management agency has not received a response from BCSS or designee after 7 days, call BCSS or designee to check on the status of the PA request.

Use the checklist in Appendix B to verify all the forms necessary to obtain a PA number have been enclosed. Incomplete packets will be returned.

Medicaid Numbers

Verify the 13 digit Medicaid number for the recipient.

Conversion from Group Home or Developmental Center Discharge

Case management agencies may be eligible to be paid for up to 4 months prior to discharge. Include the approval page of the CPOC, Form 148 (with the reason for discharge noted) and all progress notes for the four month time period prior to discharge. BCSS or designee will forward to BCSS State Office Case Management Administrator for review and approval.

Data Submission

Case management agencies are required to submit data no less than weekly to BCSS or designee.

Freedom of Choice Forms

Under no circumstance will a PA number be issued to a case management agency prior to the FOC signature date.

7.1 REIMBURSEMENT

7.1.1 GENERAL REQUIREMENTS

Candidates for case management services must be Medicaid eligible. Medicaid eligibles must be certified as a member of the targeted populations by the Medicaid agency or its designee. Payment for targeted or waiver case management services is dictated by the nature of the activity and the purpose for which the activity is performed. These activities must be related to and obtain the outcomes identified in the CPOC. All case management services billed must be provided by qualified case managers and meet the DHH definition of Case Management, "services provided by qualified staff to the targeted or waiver population to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services."

- Case management does not consist of the provision of other needed services, but is to be used as a vehicle to help an eligible recipient gain access to the services specified in the approved CPOC. A general rule of thumb for providers to follow is if there is no interaction in person, by telephone, or in correspondence on behalf of the recipient, it is most likely not an allowable case management activity without sufficient justification.

- This definition encompasses assisting eligible recipients in gaining access to paid services and unpaid natural or generic community resources and supports, including:

  - Identifying services and supports needed to assist the recipient in attaining or maintaining the personal outcomes envisioned by the recipient.

  - Face-to-face home visits as required in the Covered Services section of the manual.

  - Building support for recipients with the most appropriate providers of supports and services.

  - Building informal supports

  - Monitoring to ensure needed services and supports are received as described on the approved CPOC.

- Reimbursement for Institutionalized Recipients

For waiver participants who are institutionalized (enter a hospital, nursing facility, or ICF/MR), case management that is a waiver service, such as Children's Choice and Elderly Disabled Adult cannot be billed during the time the recipient is institutionalized.

7.1.2 FEDERAL REGULATIONS

Federal regulations require that the Medicaid Program ensure that payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority such as an administrative function or as an integral part of a covered service. Therefore, **case management providers must not bill Medicaid for case management services at the same time they bill another funding source for the same service.**

- A technical amendment (Public Law 100-617) in 1988 specifies that Medicaid is not required to pay for case management services that are furnished to recipients without charge. This is in keeping with Medicaid's longstanding position as the *payer of last resort.*

- With the statutory exceptions of case management services included in Individualized Education Programs (IEP) or Individualized Family Service Plans (IFSP) and services furnished through Title V public health agencies, payment for case management:

  - Cannot be made when another third party payer is liable;

  - Cannot be made for services for which no payment liability is incurred.

7.1.3 PROVISIONS FOR REIMBURSEMENT

The reimbursement rate for optional targeted and waiver case management services is a monthly rate as defined by negotiated amount in the contract for contracted agencies, or the amount specified by the Bureau, which is associated with intake, ongoing assessment, planning (development of the CPOC or IFSP), building/implementing supports, monitoring support strategies and transition closure. These fees are established based on the cost of providing these services to an eligible recipient of a target or waiver group.

All case management activities must lead to the presence of the personal outcomes defined and prioritized by the recipient during the person centered planning process, and/or be associated with organizational processes which lead to the presence of personal outcomes for the

individuals served. All case management activities must be appropriately documented as specified in the *Record Keeping Documentation* section and *Covered Services* section of this manual.

- Only one type (target or waiver) of case management can be billed per recipient in a calendar month. The first type of billing during the month is the only type payable in that month. Any other type will be denied.

- Duplicate claims (same recipient, same or different provider on the same date of service) will be denied.

- All claims will be billed after services have been rendered with date of service being the last day of the month in which the services were rendered (i.e. services for July would be submitted for payment with **the span of dates of service July 1- July 31 and can not be submitted for payment before July 31.)**

- Billed case management services shall be monitored through the use of provider record review, recipient survey for the verification of services provision and quality of service, and verification of contacts made on behalf of the recipient. See *Sanctions* for more information.

- Each recipient must have only one primary case manager. Case managers must maintain a separate record on each eligible recipient which clearly substantiates all claims for case management service provided in accordance with information found in the *Record Keeping/Documentation* section of this manual which includes:

  - Assessments,
  - Progress notes,
  - Progress summaries,
  - Face-to-face visits at the periodicity required by the target or waiver of case management being provided.

- Documentation in CMIS must be current prior to billing for service.

At the end of the first year or April 1, 2000, or when the CPOC states goals will be met; providers must meet an overall mean of thirteen (13) goals per agency. Failure to meet; outcomes will result in a review of recipients' records to verify services delivered, and also one or more of the following actions:

- Recoupment,
- Sanctions, and
- Loss of enrollment.

7.1.4 REIMBURSEMENT RATES AND CODES

CASE MANAGEMENT CODES AND FEES		
Target/Waiver Group	**Procedure Code**	Monthly Rate
Developmentally Disabled (MR/DD Waiver)	Z0182	Contracted Fee
Infants and Toddlers w/ Special Needs	Z0199	$115.00
HIV	Z0196	$99.00
High Risk Pregnant Women	Z0197	$57.00
Elderly/Adult Disabled Waiver	Z0195	$99.00
Children's Choice	ZE001	$125.00
Nurse Home Visit	Z0305 -Mother Z0307 -Child	
EPSDT	Z0309	Contracted Fee

7.1.5 NON-ALLOWABLE COSTS

Time spent in activities which are not a direct part of a contact are not Medicaid services and therefore, not billable. The following examples of activities are not considered targeted case management services for Medicaid purposes and are not reimbursable by the Medicaid Program as case management:

- Outreach, case finding or marketing,
- Counseling or any form of therapeutic intervention,
- Developing general community or placement resources or a community resource directory,

- Legislative or general advocacy,
- Professional evaluations,
- Training,
- Providing transportation,
- In-service training, supervision,
- Discharge planning EXCEPT: 10 days (30 days for Developmentally Disabled Waiver Participants) before discharge from an inpatient facility to assist the recipient in the transition from inpatient to outpatient status, and in arranging appropriate services and 10 days after institutionalization or hospitalization to arrange for closure of community services,
- Intake screening which takes place prior to and is separate from assessment,
- General administrative, supervisory or clerical activities,
- Record keeping,
- General interagency coordination,
- Program planning,
- Medicaid billing or communications with Medicaid Program,
- Running errands for family (shopping, picking up medication, etc.),
- Accompanying family to appointments or recreational activities, waiting for appointments with family,
- Activities performed by agency staff other than the primary case manager,
- Accompanying another case manager for safety reasons.

7.2 FINANCIAL REQUIREMENTS

7.2.1 PRELIMINARY BUDGET

Preliminary budgets are required from all providers of DHH funded case management services.

- Experienced case management providers must submit actual costs incurred during the one (1) year preceding the effective date of DHH or Medicaid enrollment.

- Potential providers must submit an estimated budget for each application for each target population served and each DHH region served.

- All budgets must include at least the following classifications of costs and explanation of cost basis:

  - Anticipated number of recipients
  - Organizational chart
  - Case manager and supervisor salaries including benefits
  - Support staff salaries and benefits
  - Supervisory/administrative/monitoring salaries and benefits
  - Multi-disciplinary team costs (high risk pregnant women only)
  - Travel expenses
  - Telephone/mail expenses
  - Other operating expenses
  - Overhead (office space costs)
  - Training costs
  - Percentage of costs attributable to Medicaid eligible recipients

7.2.2 COST REVIEWS AND AUDITS

Cost reviews and/or audits will be conducted based on allowable cost in accordance with the guidelines prescribed by the ***Provider Reimbursement Manual-HIM 15*** not to exceed limitations established by the Medicaid Program.

For contracted case management agencies, the contractor must provide a yearly external audit of the Case Management agency and any subcontractors based on allowable costs in accordance with General Accounting Practices. The first audit will cover the time period from the contract start date to June 30, 2003. The second audit will cover the time July 1, 2003, to June 30, 2004. The third audit will cover the time period July 1, 2004 to the end of the contract period. Audit reports must be sent within thirty (30) days after completion of the audit, but no later than six (6) months after the end of the audit period. Agencies shall not have outstanding or unresolved audit disclaimers with BHSF Institutional Reimbursement. This will be reviewed through out the year.

SECTION 8
RECORD KEEPING/DOCUMENTATION

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8.0 GENERAL RECORD KEEPING

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

8.01 COMPONENTS OF RECORD KEEPING

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

- The provider must keep sufficient records to document compliance with DHH case management requirements for the target or waiver populations served and the provision of case management services.

- A separate case management 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 each charge is due and proper prior to payment.

- 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.

8.02 RETENTION OF RECORDS

The case management agency must retain 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.

- Records involving matters of litigation must be kept until litigation is settled or as prescribed above, whichever is longer.

*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. The provider is required to store and protect all records for the time period described above.***

8.03 CONFIDENTIALITY AND PROTECTION OF RECORDS

Records, including administrative and recipient, must be the property of the case management agency and the agency, as custodian, must secure the records against loss, tampering, destruction or unauthorized use throughout the retention period whether the agency is in operation or closed.

- 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 from which recipients or their families might be identified, releasing such information 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).
- A provider must, upon request, make available information in the case records to the recipient or legally responsible guardian. If, in the professional judgement of the administration of the case management 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 of 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. If the case management provider establishes a satellite office, regardless of reason, records must be maintained at the enrolled site. No exceptions to this requirement will be granted.

NOTE: Under no circumstances should providers allow case management staff to take case records on recipients out of the office.

8.04 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.

8.1 ADMINISTRATIVE FILES

The provider's administrative files must be current at all times and 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, time sheets, roster of employees, and caseload by case manager,
- Annual budgets, audit reports and accounting records,

- Master list of all service providers to whom the provider refers recipients, (this shall be all enrolled service providers for that area as maintained by BCSS on the Internet),
- Provider's policies and procedures,
- Documentation of corrective action taken as a result of external or internal reviews,
- Plan for coverage of caseload increases,
- Plan for 24 hour coverage through the toll free phone number,
- 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, and self-evaluation,
- 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 populations(s) of recipients served,
    - Intake, transfer and closure criteria,
    - Written eligibility criteria for each service provided,
    - Services to be provided,
    - Schedules of any fees for services, including a sliding fee scale, which will be charged to non-Medicaid recipients, if applicable,
    - Method of obtaining opinion from the recipient regarding their satisfaction with services, and

- A current comprehensive resource directory of community service providers 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, allowances and refunds will be recorded as a reduction of the cost to which they relate.***

- All fiscal and other records concerning case management 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.

8.2 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, and

    - There must be written grievance procedures that allow employees to make complaints without 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 (must include the month, day and year that coincides with each job),
- Three (3) references,
- Valid driver's license for operating a vehicle and valid automobile insurance,
- Fingerprinting information,
- Verification of all degrees and 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, and
- Time sheets for all times on duty.

Agencies are responsible for verifying staff qualifications. If staff in an agency are found to be unqualified, this will result in one or more of the following: recoupment of payment of all services provided by that staff member, sanctions, or loss of enrollment.

An employee must have reasonable access to his/her personnel file and must be allowed to add any written statement he/she wishes to make to the file at any time. A provider must not release a personnel file without the employee's written permission except according to state law.

8.3 RECIPIENT RECORDS

A provider must have a separate written record for each recipient served by the case management agency.

8.3.1 ORGANIZATION OF RECORDS, RECORD ENTRIES AND CORRECTIONS

- The organization of individual case management 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 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, and
  - Reviewed by the supervisor, if required.

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

8.3.2 COMPONENTS OF RECIPIENT RECORDS

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

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

- 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,
  - Closest living relative,
  - Education,
  - Marital status,
  - Name and address of current employment, school, or day program, as appropriate,
  - 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, and
- Signature of the staff member gathering the information.

- Documentation of the need for ongoing case management services and other services.

- Documentation verifying that the recipient meets the eligibility requirements of the target or waiver populations.

- Medicaid eligibility information for Medicaid eligible recipients.

- A copy of an assurance of freedom of choice of providers, confidentiality, grievance procedures, etc. signed by the recipient.

- Copies of any required professional evaluations, case management assessments and other reports and information concerning the recipient's medical, social, familial, cultural, developmental, legal, educational, vocational, psychiatric and economic status, as appropriate and as specified in the *Covered Services Section* of this manual to support the initial CPOC/IFSP and modifications in the CPOC/IFSP.

- Complete and current CPOC/IFSP as specified in the *Covered Services Section* of this manual signed and dated by the case manager and recipient.

- Progress notes must reflect each entry into the service log.

- Progress summary written for the time period required for each waiver population as described in the chart located in Appendix C (Documentation Schedule).

- Reason for case closure and any agreements with the recipient at closure.

- Service logs describing all contacts, services delivered and/or action taken identifying the recipients involved in service delivery, the date and place of service, the content of service delivery and the services relation of the contact to the CPOC/IFSP.

- Copies of all pertinent correspondence.

- At least six (6) months of current pertinent information relating to services provided. Records older than six (6) months may be kept in storage files or

folders, but must be available for review.

- If the provider is aware that a recipient has been interdicted, a statement to this effect must be noted.

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

- Monitoring reports of waiver service providers to ensure that the services outlined in the Comprehensive Plan of Care were delivered as specified, including the progress of the recipient in meeting the outcomes.

- Service Logs

  Service logs are the means for clearly documenting allowable services billed. Service logs must reflect service delivered and be the "paper trail" for services delivered, and contain a chronology of events and contacts which supports justification of critical case management elements for Prior Authorization of services in the CMIS system. Each service contact is to be briefly defined (i.e. telephone call, face to face visit) with narrative in the form of a progress note.

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

    - Name of recipient,

    - Name of case management agency and employee providing the service,

    - Service agency contact telephone number,

    - Date of service contact,

    - Start and stop time,

    - Place of service contact

    - Purpose of service contact,

- Personal outcomes addressed
- Other issues addressed
- Content and outcome of service contact (Information/items discussed and decisions reached),
- There must be service log entries corresponding to each recorded case management activity on the service log 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. The narrative is in the form of a progress note as described below.
    - Services billed must clearly be related to the current approved CPOC/IFSP. All service log entries must be clear as to who was contacted, where the contact took place and what case management activity took place. Use of general terms such as "assisted recipient to" and "supported recipient" do not constitute adequate documentation.
    - Service 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.

- Progress Notes

Progress notes are the means of recording in a narrative form actions and activities taken on behalf of an individual recipient. Progress notes should reflect each entry in the service log and elaborate on the substance of the contact. Progress notes must:

- Be clear as to who was contacted, how and where the contact took place and what case management activity took place, and for which outcome.
- Must fully describe the actions or activities noted on the service log. Should be recorded and entered in the record as activities occur but no less than weekly.
- Be recorded daily or as they occur when there is frequent activity or significant changes occur in the recipient's service needs and progress.

- Include the name, functional title and signature of person making the entry and include full date of documentation.

- Progress Summary

The progress summary is a summary that includes the syntheses of all activities for a specified time period (see chart in Appendix C for the requirements for each population) which addresses significant activities, summary of progress/lack of progress toward desired outcomes and changes to the social history. This summary should be of sufficient detail and analysis to allow for evaluation of the appropriateness of the current CPOC. This summary should provide sufficient information for use by other case managers or their supervisors, and allows for evaluation of case management activities by program monitors. Progress summary must:

- Record activities and actions taken, by whom, and progress made; and indicate how the recipient is progressing toward the personal outcomes in the CPOC/IFSP.

- Document delivery of each service identified on the CPOC/IFSP.

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

- Include the name, functional title and signature of author/person making the entry and include full date of documentation.

- Be completed quarterly or as required by the guidelines specific to the population being served.

- Be entered in the recipient's record when a case is transferred or closed.

8.3.3 AVAILABILITY OF RECIPIENT RECORDS

Providers must make all necessary recipient records available to appropriate state and federal personnel at all reasonable times. Providers must always safeguard the confidentiality of recipient information. Under no circumstances should providers allow case management staff to take records home. The case management agency can release confidential information only under the following conditions:

- By court order; or
- By the recipient's written informed consent for release of information. In cases where the recipient has been declared legally incompetent, the individual to whom the recipient's rights have devolved must provide informed written consent.

8.3.4 Storage of Recipient Records

Providers must provide reasonable protection of recipient records against loss, damage, destruction, and unauthorized use. Administrative, personnel and recipient records must be retained until records are audited and all audit questions are answered or five (5) years from the date of the last payment, whichever is longer. Records involving matters of litigation must be kept until litigation is settled or as prescribed above, whichever is longer.

SECTION 9
PROGRAM MONITORING

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9.0 INTRODUCTION

Case management services are closely monitored to assure compliance with BCSS policy as well as applicable state and federal regulations. BCSS staff conduct on-site reviews of DHH enrolled case management agencies. These reviews monitor each case management agency's compliance with DHH Provider Enrollment participation requirements, continued capacity for service delivery, quality and appropriateness of services provided to the target or waiver population, and the presence of the personal outcomes defined and prioritized by the recipients served.

Administrative records, personnel records, and a sample of recipient records are also reviewed as well as billing practices. In addition, case management 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 case management 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.

The BCSS Regional Office staff is available to answer questions regarding the monitoring of case management.

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 obvious cases of fraud. General case management monitoring procedures as well as target population specific monitoring procedures are described in this section.

9.1 ON-SITE REVIEWS

On-site reviews are scheduled with the case management provider agency and conducted by BCSS Regional staff and in some instances representatives of the Department of Education (DOE) on a regular basis to ensure compliance with program requirements, review billing practices, and ensure that case management services provided are appropriate to meet the needs of the recipients served. The "BCSS Case Management monitoring Report Forms" (Appendix B) are utilized by the BCSS Regional staff during the on-site review and following the review to summarize review findings. The on-site review includes the components listed

below.

9.1.1 ON-SITE ADMINISTRATIVE REVIEW

The Administrative Review includes:

- Review of administrative records
- Other agency documentation and
- Provider agency staff interviews.

All these methods determine continued compliance with provider participation requirements. Failure to respond promptly and appropriately to BCSS Case Management monitoring findings may result in sanctions, liquidated damages and/or recoupment of payment according to Section 11of this manual.

9.1.2 ON-SITE PERSONNEL RECORD REVIEW

The Personnel Record review includes:

- A review of personnel files,
- Payroll records,
- Time sheets,
- Current organizational chart,
- Staff case load records,
- Provider agency staff interviews are conducted to ensure that staff qualifications related to the following are met:

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

9.1.3 ON-SITE INTERVIEWS

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

- A sample of the recipients served by each case manager;
- 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 and other employees of the case management provider.

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

9.1.4 ON-SITE RECIPIENT RECORD REVIEW

Following the interviews described above, the BCSS Regional staff may review the case records of a representative sample of recipients served. The records will be reviewed to ensure that the case manager activities are associated with the appropriate services, e.g. intake, ongoing assessment, planning (development of the CPOC or IFSP), monitoring support strategies, transition/closure, and that these activities are effective in assisting the recipient 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.

- Record documentation is reviewed to ensure that the services reimbursed were:
    - Identified in the CPOC/IFSP;
    - Provided;
    - Documented properly;
    - Appropriate in terms of frequency and intensity; and,
    - Relate to personal outcomes on the CPOC or IFSP.
- BCSS Regional Staff will review the intake documentation of the target population 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.

- The "BCSS Case Management Monitoring Report Form" is completed on each record reviewed.

9.1.5 QUALITY IMPROVEMENT PLAN

The case management agency's approved continuous Quality Improvement Plan (QIP) is reviewed to ensure that the provider is providing quality services and is responsive to the needs of recipients, including the personal outcomes defined and prioritized by the recipients. A copy of the components of QIP can be found in Appendix C.

- 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 provider agency's involvement of recipient input in the improvement in quality of service provision is also reviewed.

The case management agency must submit two (2) copies of the QIP to:

Department of Health and Hospitals
Bureau of Community Supports and Services
Case Management Program Administrator
446 North 12th Street
Baton Rouge, Louisiana 70802-4613

9.2 CASE MANAGEMENT AGENCY SELF-EVALUATION

Each August 1 after the beginning of the first case management contract and annually after the first report, the case management agency is required to conduct an agency self-evaluation and to submit a written report on the findings of the self-evaluation along with appropriate documentation to the BCSS Case Management Program Administrator. These findings are subject to the approval of BCSS. More frequent self-evaluation by the case management agency may be required as part of a corrective action plan.

The self-evaluation examines elements of the overall agency administration, the agency quality improvement plan, case management recipients' personal outcomes and case record documentation. The purpose of the self-evaluation is to assess, a representative sample of recipients served by each case manager, the presence of personal outcomes, as defined and

prioritized by the recipient and the presence of required case record documentation. Additionally, the quality improvement plan as well as overall agency function is assessed. The self-evaluation will assist the agency in preparing for on-site review by BCSS and DOE staff as well as a review by representatives of the DHH Quality Management and Program Evaluation staff.

The report of the agency's self-evaluation report will consist of a narrative that begins with a brief descriptive statement about the agency which includes information about the target population(s) served, number of case managers, size of case loads, geographic location, and other pertinent factors. The body of the narrative describes the methodology used, the sample selection and size, the findings and conclusions, and recommended strategies for improvement. Sample forms and other documentation are to be included. Agency strengths, weaknesses, and major problem areas should be identified and discussed. If needed, the report should contain a written request or plan to acquire technical assistance, training and/or support. If the findings indicate that the case management agency is not working toward the personal outcome requirements and/or case record documentation requirements, then the self-evaluation report must also include a quality improvement strategy describing how the case management agency will address issues with recipient case managers and/or implement changes in organizational processes, and otherwise make systematic efforts to meet the case management personal outcome and case record documentation requirements.

9.2.1 METHODS OF OBTAINING INFORMATION

Methods of obtaining information may include the following:

- A review of documents and records;
- Questionnaires and interviews with staff, providers, recipients, and others who know the recipient best, and
- Direct observation of program activities.

Sample Selection

A representative sample of recipients served by each case manager must be selected. The sample should be random in nature and distributed among all case managers. For example, if a 10% random sample is selected, then 10% of each case manager's cases must be included. A 10% sample of agency cases without regard to case manager would not be an acceptable sample. To be truly random, each case within a given case load should have an equal chance of being chosen. The same sample is to be used to evaluate records, personal outcomes and satisfaction. This method will enable the agency to determine if it is generally meeting the needs of its recipients.

9.2.3 ELEMENTS OF THE SELF-EVALUATION

The following is a list of components that should be addressed in the agency self-evaluation.

Administrative and Policy Review

Below are areas for review:

- A review of the current organizational chart. Does the chart reflect the current agency organization? Are the lines of authority correct? Are the agency employees shown in their correct positions?

- A review of the governing body and minutes of the board meetings. Is there a current list of members and officers of the governing body? Is the board involved with the program? If so, how does the board relate to the program?

- A review of the policy and procedures manual, including complaint/grievance/appeal procedures and abuse and neglect procedures. Does it need updating? What is the total number of complaints, grievances, and appeals? What is the nature of the complaints, grievances and appeals? Have they been resolved? How many were resolved in favor of the recipient? Regarding abuse and neglect policies and procedures, what is the number of incidences? What is the nature of the abuse and neglect complaints? What was the resolution of the incidences? Did the existing protocol work as was expected? Were changes made in the protocol? If so, what changes were made.

- A review of personnel records and staffing issues. Do staff meet the requirements for the position held? Does staff coverage meet standards? Is staff recruitment a problem? Is staff retention a problem? What is the turnover rate?

- A review of payroll and time sheets. Have there been any cases of fraud or abuse? Are employees being paid on time?

- Is employee training occurring as required by BCSS? What are some of the training topics?

- A review of the agency's financial status. Is there a comparison of the planned or preliminary budget vs actual budget for the time frames studied? Are there

problems in the billing procedures? What is the agency's financial status? Has there been an independent audit? If so, what are the findings?

- A review of the management information system. Is the management information system adequate? Can necessary reports be generated? Is the equipment adequate? Could more agency information be computerized?

- Is The Comprehensive Directory of Existing Formal and Informal Services up-to-date? Are there resource limitations?

- Administrative areas of concern. Are there significant administrative problems?

The Quality Improvement Plan

The Quality Improvement Plan (QIP) along with minutes of the Quality Assurance Committee should be reviewed. A review of selected agency documents or selected indicators from the QIP should be made. Changes since the last review should be noted. If aspects of care are not within the target thresholds, then this self-evaluation should contain the corrective action plans and an assessment of the effectiveness of these plans. What are the major areas for improvement identified by the Quality Improvement Program? Which aspects/indicators were reviewed? What were the results? What improvement strategies were developed as a result of the Quality Improvement Program?

Case Management Recipients' Personal Outcomes

Using interviews with the recipients selected in the representative sample and with others who best know these recipients, the agency must assess the presence of personal outcomes in accordance with outcome measures approved by BCSS. The additional individuals to be interviewed can include family, friends, service, and support providers, professionals, and other members of the recipient's network of support.

The personal outcomes should be defined and prioritized by the recipients in the sample. They are based on the recipient's viewpoint, goals and past experiences. Personal outcomes are to be measurable, with action steps, strategies and within Council guidelines. An assessment of the degree or percentage to which the outcomes are being met is to be made. What personal outcomes were identified in the representative sample? Is progress toward personal outcomes being made by recipients in the representative sample? What were identified as the main barriers to accomplishing the personal outcomes? How may accomplishing personal outcomes be improved? Were there any corrective action plans developed? What is the time frame for

implementing/completing the plan?

In 1997 the Council on Quality and Leadership in Supports for People with Disabilities issued the following revised edition of Personal Outcome Measures. There are seven domains and 25 outcome measures.

9.2.4 PERSONAL OUTCOMES FACTORS AND MEASURES

IDENTITY	People choose personal goals. People choose where and with whom they live. People choose where they work. People have intimate relationships. People are satisfied with services. People are satisfied with their personal life situations.
AUTONOMY	People choose their daily routine. People have time, space, and opportunity for privacy. People decide when to share personal information. People use their environments.
AFFILIATION	People live in integrated environments. People participate in the life of the community. People interact with other members of the community. People perform different social roles. People have friends. People are respected.
ATTAINMENT	People choose services. People realize personal goals.
SAFEGUARDS	People are connected to natural support networks. People are safe.
RIGHTS	People exercise rights People are treated fairly.
HEALTH AND WELLNESS	People have the best possible health. People are free from abuse and neglect.

People experience continuity and security.

While each recipient's outcomes may be different, these outcome factors and measures may be used to collect and compile data.

Recipient Satisfaction

The agency will develop a survey tool or method of obtaining an opinion from the same representative sample regarding its satisfaction with the case management services provided This survey should address specific areas that the agency wishes to know about and end with a question of over-all satisfaction. The report should indicate how and when the survey was conducted and by whom. What were the overall findings of the survey? What areas were identified as problem areas? How were the results used or incorporated in the program?

The following are areas that might be covered:

- Items from the previously mentioned Personal Outcomes Factors and Measures.
- Availability - What can be obtained?
  - Services I need can be obtained.
  - Ability to schedule desired services.
  - Convenient appointment times.
- Accessibility - Ease of reaching service
  - Location of services is convenient.
  - Transportation is available.
- Appropriateness - Care is relevant to recipient's needs.
  - I am receiving the type services I need.
  - Receiving the correct amount of services.
- Acceptability
  - Services are the ones I prefer.
- Effectiveness - What was intended?

  - Services are improving my situation.

- Extensiveness

  - I can get enough of the services I need.
  - Frequency of services is acceptable.

- Responsiveness

  - Timeliness - Services are provided to the recipient at the most beneficial or necessary time.
  - Follow through.

- Professionalism

  - Worker listened to me.
  - Phone calls were returned.
  - Treated with respect.
  - Positive attitude.
  - Helpful.

- Awareness of Agency

  - Knowledge of how to obtain services.
  - Knowledge of agency complaint/grievance/appeal procedures.
  - Knowledge of how to change worker/agency.

- Personal Issues

  - Satisfaction with support/network.
  - Satisfaction with personal life situation.
  - Satisfaction with case management plan.
  - Personally feel safe in living situation.

- Quality

  - Satisfaction with assigned case manager.
  - General satisfaction with the services I receive.

- General satisfaction with my progress toward my personal goals.

Case Record Review

An assessment of case records for recipients in the **same** representative sample should reveal the presence of the following required documentation as included in *The Case Management Manual*, Section 8, Record Keeping and Documentation:

- Separate record for each recipient that fully documents services for which payments have been made. Sufficient detail to enable DHH to verify that charges are proper prior to payment.
- Identifying information on a standard form.
- Documentation of the ongoing need for case management.
- Documentation of the verification that the recipient meets the eligibility requirements for the waiver group.
- Medicaid eligibility information for Medicaid eligible recipients.
- Copy of assurances for freedom of choice of providers, confidentiality, grievance procedures, etc. signed by the recipient.
- All assessments written, signed, dated, and documented in the case record.
- The assessment

  - Identifies the recipient's strengths, needs, interests, preferences, capacities, resources and priorities as related to the personal outcomes desired by the recipient/guardian.
  - systematically organizes assessment information about the recipient.
  - identifies how the recipient/guardian defines and prioritizes the personal outcomes.
  - indicates the current status of the recipient in achieving the desired personal outcomes.

- Complete CPOC/IFSP signed and dated by the case manager and recipient and approved by the case management supervisor. The CPOC is outcome-oriented, individualized and time-limited.
- Complete progress notes summarizing case management services, interventions provided and progress toward objectives. Entered in the record, preferably weekly, but at least monthly and signed by the primary case manager.
- If case closed, reason for closure and any agreements with client at time of closure.
- Service logs.

- Correspondence.
- At least 6 months of current pertinent information relating to services provided.
- If recipient has been interdicted, record must include a statement to this effect.
- Indication of treatment or medication necessary for any serious or life threatening medical condition or known allergies.
- Monitoring reports from waiver service providers ensuring that services outlined in CPOC were delivered.
- Case record entries corresponding to each recorded case management activity.
- Quarterly Progress Notes in addition to the minimum monthly recording. All priority personal outcomes must be addressed in the Quarterly Progress Note, either separately or in logical, related combinations.
- Summary entered in the recipient's record when a case is transferred or closed.

Further, assessment of the case records for recipients in the representative sample should reveal the existence of the following covered services as detailed in Section 5 of the *Louisiana Medicaid Program, Case Management Services Manual:*

- Intake - Interview with recipient within three (3) working days of referral. Determine recipient's eligibility and need for case management services.

- Ongoing Assessment - The process of gathering and integrating formal/professional and informal information. The assessment must identify the recipient's strengths, needs, interests, preferences, capacities, resources and priorities as related to the personal outcomes desired by the recipient/guardian. The assessment defines the recipient's personal outcomes and the recipient's priorities for the outcomes. The initial assessment must begin within seven (7) days and be completed within 30 calendar days of the referral.

- Comprehensive Plan of Care (CPOC) - The CPOC is developed through a collaborative process involving the recipient and his network of support. It must be outcomes-oriented, individualized and time limited. The recipient/guardian must be directly involved and participate in the decision making process. The CPOC must be forwarded to BCSS within 45 calendar days from date of referral, except for High Risk Pregnant Women whose CPOC must be completed within 30 days of the prenatal risk assessment.

- Building/Implementing Supports - Support strategies are the specific ways in which informal, natural community supports, other kinds of choices or opportunities, and paid formal services will be explored, developed or accessed to achieve or

maintain outcomes. Responsibilities and services must be assigned.

- Monitoring Support Strategies - The case manager must assist the recipient/guardian to evaluate and monitor the effectiveness of the support strategies and service delivery. The recipient must be contacted within the first 10 working days after the initial CPOC in completed to assure appropriateness and adequacy of service delivery. There must be a quarterly face-to-face home visit to assess effectiveness and to assist in revisions. Face-to-face visits for high risk pregnant women must be monthly. There must be documentation of the action plan resulting from the face-to-face visit in the quarterly progress note. A reported major change in status of the recipient/guardian must trigger reassessment.

- Transition/Closure - This occurs in response to request of recipient/guardian or if the recipient is no longer eligible for services. The recipient/guardian should be a full participant in the process. The case manager must complete a final written reassessment identifying any unresolved problems or needs and discuss with the recipient/guardian methods of negotiating their own service needs.

- Procedures for Changing Providers - Recipients/guardians may change case management agencies and case managers according to BCSS policy. Upon receipt of the completed form, the previous provider must send to the new provider copies of the current CPOC, current assessments upon which CPOC is based, number of services used in the calendar year, current and previous quarter's progress notes, Form MR/DD - 14, and Form 90-L.

What were the findings of the case record review? Were the documents completed in a timely manner? Were the documents completed accurately? Which documents were missing? Was there consistency in the filing of material in records? Were transitions and provider changes investigated to determine any agency problems that might be corrected?

SUBMISSION OF THE SELF-EVALUATION REPORT

The case management agency must submit two (2) of its self-evaluation report to:

Department of Health and Hospitals
Bureau of Community Supports and Services
Case Management Program Administrator
446 North 12th Street
Baton Rouge, Louisiana 70802-4613

9.3 MONITORING REPORT

Upon completion of the on-site review, the BCSS Regional team discusses the preliminary findings of the review in an exit interview with appropriate staff of the case management agency. The BCSS 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 case management 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 monitoring staff,
  - Recommended corrective action, and

Although the monitoring report has an educational component, any inappropriate reimbursement will be identified for possible recoupment action. The BCSS Regional staff will review the monitoring reports and submit recommendations to the Case Management Program Administrator to assess any sanctions or liquidated damages as appropriate.

9.4 CORRECTIVE ACTION REPORT

The case management 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 case management provider agency is afforded an opportunity to discuss or challenge the BCSS monitoring findings.

Upon receipt of the written Plan of Corrective Action (POC), the BCSS staff reviews the case management agency's plan within **90 days** to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, BCSS 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 provider agency has had this opportunity to address the review findings, the BCSS staff may send a memorandum to Surveillance and Utilization Review System (SURS) Unit recommending a recoupment amount.

9.5 MEDIATION (OPTIONAL)

In the course of monitoring duties, an informal hearing process may be requested. The case management 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 BCSS at:

BCSS
ATTN: Informal Discussion
446 North 12th Street
Baton Rouge, LA 70802-4613
(225) 219-0200

Every effort will be made to schedule a hearing at the convenience of the case management agency. This request must be made within the time limit given for the corrective action recommended by the BCSS. The case management 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 staff facilitating the discussion solicits representation from other sections within BCSS as well as other persons within BHSF to participate in the informal hearing process. The BCSS facilitator should solicit between five to seven persons to participate.

When the informal hearing occurs, the BCSS facilitator who serves as the convener of the hearing, keeps the atmosphere informal. The case management agency is given the floor to present its case, to explain its disagreement with the monitoring findings, and/or to present new information. After the case management agency has explained its position, the agency representatives are asked to leave the hearing and are advised of the date that a written response will be sent. The agency is reminded of its right to a formal appeal.

The BCSS facilitator 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 case management agency and may contain directions with time-lines for completion.

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

9.6 FRAUD AND ABUSE

When BCSS Regional staff detects patterns of abusive or fraudulent Medicaid billing, the case management providers will be referred to the Surveillance and Utilization Review System (SURS) of the Medicaid Program for investigation and sanctions, if necessary. Specific information regarding fraud, abuse and SURS is found in Section 11 of this manual. BCSS 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
CLAIMS FILING

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2.0 CLAIMS SUBMISSION AND PROCESSING

Claims for EPSDT Psychological and Behavioral Health services using the HCFA 1500 universal claim form (revised 12/90). Supplies of this form can be obtained from national claim forms vendors or from the office indicated below:

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

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. Claims with attachments cannot be billed via EMC. For more information or to request EMC specifications, the Unisys EMC Coordinator may be contacted at (225) 237-3303. A list of billing and management companies that provide electronic billing services is available from the fiscal intermediary Unisys.

2.1 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 billed before Medicaid will pay on a claim for services provided to 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 submission of the claim to the third party carrier. 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 carrier'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.

2.2 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 the diagnosis and chief complaint as well as the following:

- 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

2.3 TIMELY FILING GUIDELINES

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

- Straight Medicaid claims must be filed within 12 months of the date of service.
    - KIDMED claims must be filed within sixty (60) days 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) coverage must be filed within 12

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

- Claims for recipients with retroactive eligibility, 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 eligibiltity will be forwarded to the Medicaid Program for review and authorization.

2.3.1 TIPS ON TIMELY FILING FOR PROVIDERS

It is the providers responsibility to complete the claims form correctly and to attempt to resolve any 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.

Providers are given notice that have been denied for payment by means of the Remittance Advice (RA.) A three (3) digit error code indicating the error is printed for each claim. These codes are listed with a brief explanation being given 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 who are having problems billing. You may contact Provider Relations at 1-800-473-2783 or (504) 924-5040 to request.

2.3.2 CLAIMS FOR DATES OF SERVICE OVER ONE YEAR OLD

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, reference the individual recipient and date of service, and verify the original and subsequent dates of submission to the fiscal intermediary. 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.

2.3.3 CLAIMS FOR DATES OF SERVICE OVER TWO YEARS OLD

Claims with dates of service over two years old shall not be submitted to the fiscal intermediary or to the Medicaid Program for an override of the timely filing edit unless one or more of the following criteria is met.

- The recipient was certified for retroactive Medicaid benefits and the provider has filed a claim within 12 months of the date that retroactive eligibility was granted.
- The recipient won a Supplemental Security Income (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.

2.4 HCFA 1500 BILLING INSTRUCTIONS

All items marked with an asterisk "*" are required to be completed for claims processing. If these items 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.

1.04 **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.

2.5 ADJUSTING/VOIDING A PAID CLAIM

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.

2.5.1 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".

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.

2.6 HEALTH INSURANCE CLAIM ADJUSTMENT/VOID FORM 213 INSTRUCTIONS

All items marked with an asterisk "*" must be completed in order for the adjustment/void to be processed.

*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.

2.7 CLAIMS PAYMENT SYSTEM

The purpose of this section is to familiarize the provider with the claims payment system and the design and contents of the 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.

2.7.1 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 Medicaid identification number, service dates, or provider name or identification 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.

2.7.2 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.

2.7.3 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.

2.7.4 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.

2.8 HOW TO CHECK THE STATUS OF AN INTERNAL CONTROL NUMBER

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

2.9 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

2.10 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 RAs 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)

2.11 PROVIDERS 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 Relations 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 11
SANCTIONS

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11.0 GENERAL OVERVIEW

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.

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.

11.1 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.*

- 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.

11.1 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- 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.

11.1.2 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.

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

11.2 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.

11.2.1 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.

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

11.2.2 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.

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

11.3 CIVIL CAUSES OF ACTION

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.

11.3.1 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.

11.3.2 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.

11.3.3 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.

11.3.4 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.

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

11.3.5 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.

The Louisiana Medicaid Program may withhold payment to any provider who fails to meet the requirements for participation in the Louisiana Medicaid Program or for any other authorized reason.

Any provider of Medicaid services may be placed 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 of the provider's claims.

NOTE: 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.

11.5 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 12
ABBREVIATIONS/ACRONYMS/DEFINITIONS

SECTION CONTENTS

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ABBREVIATIONS/ACRONYMS/DEFINITIONS 12-2

This is a comprehensive list of abbreviations, acronyms, and definitions used in the Case Management Services 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** - Is 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** - Is 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.

Bureau of Community Supports and Services (BCSS) - Formerly Division of Home and Community Based Waivers. Functions in the Office of the Secretary in the Louisiana Department of Health and Hospitals (DHH). The BCSS is responsible for directing the coordination and approval of all services and supports necessary for the planning development, and evaluation of all Home and Community Based supports and service offered through the Waivers and targeted populations approved by Centers for Medicare and Medicaid Services (formerly known as HCFA).

Bureau of Health Services Financing (BHSF) - The Division within the Office of the Secretary of DHH responsible for the administration of the 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.

Centers for Medicare and Medicaid Services (CMS) - The Federal agency in DHHS responsible for administering the Medicaid Program and overseeing and monitoring the State's Medicaid Program. Previously named Health Care Financing Administration (HCFA).

ChildNet - Name of the program administered by the Department of Education providing early intervention services to infants and toddlers with special needs in Louisiana.

Child Search - A part of the ChildNet program in each local school board and single point of entry to identify infants and toddlers with special needs and to direct them to appropriate early intervention services.

COA - Council on Aging.

CommunityCARE - Operates in Louisiana under a Freedom of Choice Waiver granted by CMS. It is a system of comprehensive health care based on a primary care case management (PCCM) model. CommnunityCARE links Medicaid recipients with a physician, clinic, federally qualified health center, or a rural health clinic that serves as the recipient's primary care physician (PCP).

***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 case management provider agency plans to take to correct deficiencies identified by the provider's Quality Improvement Planning Committee or by BCSS Regional staff.

Cost Avoidance - Term referring to avoiding the payment of Medicaid claims when other insurance resources are available to the Medicaid-eligible recipient.

CPOC - Comprehensive Plan of Care. See Service Plan.

Crossover Medicare/Medicaid Claims - Claims received on a Medicaid-eligible recipient who has both Medicare and Medicaid coverage. (Medicare does not pay for case management services.)

Department of Education (DOE) - The state agency responsible for administering the regular and special education system in Louisiana and the designated lead agency responsible for administering the ChildNet early intervention system in Louisiana.

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.

***Disabled person** - Is 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.

Developmental Delay - Term used to describe slower than normal development of an infant or child in one or more areas.

Developmental Disability (DD) - Defined in La.R.S. 28:380 as amended in 1983 as a severe chronic disability of a person which is attributable to:

- Mental retardation, cerebral palsy, epilepsy; or autism OR,
- Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, or requires treatment or services similar to those required for these persons; AND,
- Which is manifested before the person reaches age 22; AND,
- Which is likely to continue indefinitely; AND,
- Which results in substantial functional limitations in three or more of the following areas of major life activity:

  - Self care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living

E/BD - Severely emotionally and behaviorally disturbed.

Early Intervention - Services provided to infants and toddlers (under age three) with disabilities to minimize or eliminate the disability as they mature.

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** - Is 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** - Is 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)

Family Service Coordination - Another term for case management provided to infants and toddlers with special needs.

Family Service Coordinator - Another term for case manager for infants and toddlers with special needs.

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).

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.

Human Immunodeficiency Virus (HIV) - The virus which causes Acquired Immunodeficiency Syndrome (AIDS).

IFSP - Individual Family Service Plan. The service plan for an infant or toddler under ChildNet.

Individuals with Disabilities Education Act (IDEA) - Public Law 101-476 which, in Part H, authorizes services to children up to 36 months of age who have established medical conditions or who exhibit symptoms of developmental delay.

Infants and Toddlers with Special Needs - Individuals from birth through age two who are early intervention services because they are experiencing developmental delays or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay as defined by Childnet.

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.

Licensure - A determination by the DHH/BCSS that a case management provider agency meets the state requirements to provide client care services, specifically, case management/service coordination services.

Linkage - Assignment of the recipient by BCSS or designee to the case agency chosen from freedom of choice form .

Lock-In - A mechanism for restricting Medicaid-eligible recipients to a specific physician and/or a specific pharmacy to ensure appropriate use of Medicaid benefits by Medicaid-eligible recipients and/or providers. Lock-In also serves as an educational device.

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 approved 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** - Is 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)

Mixed Caseload - A caseload in which a case manager serves recipients from more than one target or waiver group.

Monitoring - A core element of case management which refers to the follow-up mechanism to assure applicability of the service plan. BCSS Regional staff is responsible for performing on-site reviews of case management providers to determine compliance with Medicaid policies and procedures.

Multi-disciplinary Team - The group of professionals involved in assessing the needs of a high risk pregnant recipient and making recommendations in a team staffing for services or interventions targeted at those needs.

Multi-disciplinary Evaluation (MDE) - The testing of an infant or toddler by a group of professionals including infant development specialists, speech therapists, physical therapists, occupational therapists, social workers, nurses, etc.

***Neglect** - Is 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)

OCDD - Office for Citizens with Developmental Disabilities (previously the Office of Mental Retardation/ Developmental Disabilities). The Office in DHH responsible for services to developmentally disabled citizens in Louisiana.

OAD - Office for Addictive Disorders (formerly Office of Alcohol and Drug Abuse (OANA) - Performs the functions of the State relating to the care, diagnosis, training, treatment, and education of those afflicted with alcohol, drug abuse and/or gambling.

OFS - Office of Family Support.

OMH - Office of Mental Health. Performs the functions of the State which provide or lead to treatment and follow-up care for individuals with mental and emotional disorders.

OPH - Office of Public Health. Develops, provides, and assures public and environmental health services to protect and enhance the health of Louisiana citizens.

Part H - The portion of the Individuals with Disabilities Education Act (often referred to as Public Law 99-457) which authorizes early intervention services for infants and toddlers with disabilities from birth through age two years and their families.

Pay and Chase - Method of payment where Medicaid pays the Medicaid-eligible recipient's medical bills and then pursues reimbursement from liable health insurance company(s) and any other liable third parties.

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.

Primary Nurse Associate - Legal term for nurse practitioner certified by the Louisiana Board of Nursing.

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.

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/Guardian - The individual receiving services, or the responsible party, or a parent. All references to recipient includes the parent or guardian if the recipient has been interdicted or is a minor.

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.

Risk Screening - Determination according prescribed criteria used to establish presence and severity of factors likely to contribute to less than satisfactory pregnancy outcomes.

Ryan White Funds - Federal funding available through DHH under the Ryan White Care Act of 1990 for comprehensive outpatient health and support services for persons with HIV including the provision of case management services for those recipients with no other reimbursement source.

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

***Self-neglect** - Is 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.

Service Planning - A core element of case management defined as the development of a written agreement based upon assessment data, observations, and other sources of information which reflect the recipient's priorities, capacities, resources, and needs.

Service Coordination - Another term for case management for infants and toddlers with special needs.

Spend-down -A term used to describe 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** - Is 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.

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.

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.

Treatment Planning - The development of specific clinical interventions that professional service providers will use to achieve treatment or rehabilitation goals. This is different from service planning used in case management.

***Trivial Report** - Is 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.

***These definitions will be used for the purposes of the Bureau of Community Supports and Services (BCSS) complaint process, the word "complaint" and "grievance" will be used synonymously.**

SERVICES AVAILABLE TO MEDICAID ELIGIBLE CHILDREN

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 Diagnosis, 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.

APPENDIX B

FORMS AGENCY IS RESPONSIBLE FOR COMPLETING

ADMINISTRATIVE REQUIREMENTS CHECKLIST
REPORT FOR CAPACITY FORM
CASE MANAGEMENT CHOICE AND RELEASE OF INFORMATION FORM
CLIENT REENTERING CASE MANAGEMENT PROGRAM (EPSDT)
CONTACT SHEET FOR CASE MANAGEMENT
CPOC FORM AND INSTRUCTIONS
EXIT CONFERENCE ACKNOWLEDGMENT STATEMENT
MEDICAID ELIGIBILITY RE-ESTABLISHED FORM (INFANT & TODDLER
NOTIFICATION OF ADMISSION, STATUS CHANGE FORM (FORM 148)
ONSITE CONTRACT CASE MANAGEMENT AGENCY FORM
PCA WAIVER PROVIDER MONITORING REPORT FORM
PRIOR AUTHORIZATION CHECKLIST
RECIPIENT RECORD REVIEW FORM
REPLACEMENT PA REQUEST FORM
SERVICE PROVIDER REPORT/COMPLIANCE REQUIREMENT CHECKLIST

CASE MANAGEMENT MONITORING REPORT FORM
ADMINISTRATIVE REQUIREMENT CHECKLIST

Region Served:_____

Quarter: _____

Provider Type : ☐ **MR/DD WAIVER** ☐ **ELDERLY/ADULT WAIVER**

Annual Licensure Visit:_____

5% Monitoring:_____

Date of Exit Interview:_____

Case Management Agency:_____

Service Provider:_____
_____
_____

Provider #:	Agency:	CEO/DESIGNEE:	
Date of Review:	Address:	Telephone Number :	License Number:

Source: Agency's Policy and Procedure Manual

REQUIREMENT	RESPONSE	COMMENTS (FOR OFFICE USE ONLY)	CORRECTIVE ACTION
A. ADMINISTRATIVE CAPACITY			
1. The agency has a Board of Directors.	☐ Yes ☐ No ☐ N/A		
2. The agency has scheduled board meetings with appropriate minutes.	☐ Yes ☐ No ☐ N/A		
3. The governing board exercises review of policy, procedures, budget, etc. on an annual basis?	☐ Yes ☐ No ☐ N/A		
4. The agency has a current table of organization with names, positions, and designated lines of authority. (Section 3-1: V, C# 4) (Section 8-1: II # 5)	☐ Yes ☐ No ☐ N/A		
5. The agency has a grievance policy and procedure for staff and recipients grievance resolutions. (Section 3-7: V, C7 RFP Grievance Procedure)	☐ Yes ☐ No ☐ N/A		
6. The agency has an abuse/neglect policy and procedure for reporting and resolution of incidents.	☐ Yes ☐ No ☐ ☐ N/A		
7. The agency maintains records of reported incidents and their deposition.	☐ Yes ☐ No ☐ N/A		
8. Is a copy of the report for capacity that identifies all case management services the contractor provide on site? ★	☐ Yes ☐ No ☐ N/A		

REQUIREMENT	RESPONSE	COMMENTS (FOR OFFICE USE ONLY)	CORRECTIVE ACTION
A. ADMINISTRATIVE CAPACITY(CONTINUED)			
9. Does the case management agency serve individuals on ventilators? ★	☐ Yes ☐ No ☐ N/A		
10. Has agency informed the recipient/family that Children's Hospital performs a higher level of services than provider under this contract?	☐ Yes ☐ No ☐ N/A		
11. Have parents/family declined Children's Hospital services? ★	☐ Yes ☐ No ☐ N/A		
B. FINANCIAL			
1. The agency's finances are maintained in accordance with accepted accounting principles and state and federal regulations. (Section 3-1: V-K) (Section 3-1: V-K #4) (Section 8-1: II #8) (8-1: II)	☐ Yes ☐ No ☐ N/A		
2. The agency has adequate commercial and general liability insurance for the protection of consumers, staff, facilities, and general public. (Date of Expiration :_____) (Section 3-9: V-K #7)	☐ Yes ☐ No ☐ N/A		
3. The agency has an annual audit.	☐ Yes ☐ No ☐ N/A		
C. LICENSING			
1. The agency has a current, case management license with the appropriate address. (Section 3-5: IV) (Section 3-6: V-B) (Section 8-4: II #4) (Date of Expiration: _____.)	☐ Yes ☐ No ☐ N/A		
D. PERSONNEL			
1. The case management agency ensures that case management services are available 24 hours a day, 7 days a week. (Call at random 1-800 number to determine if service is active.) (Section 6-15: IV-A) ★	☐ Yes ☐ No ☐ ☐ N/A		
2. The case management turnover rate does not exceed 50% annually. ★	☐ Yes ☐ No ☐ No		

REQUIREMENT	RESPONSE	COMMENTS(FOR OFFICE USE ONLY)	CORRECTIVE ACTION
D. PERSONNEL			
3. The agency adheres to maximum caseload requirements. (Section 6-17: IV-C# 1a & #2) (Check agency CAMIS print-out for case load size.)	☐ Yes ☐ No ☐ No		
4. Does the agency have any part-time case managers? If so are they approved by BCSS in writing? Is the approval still within the effective dates? ★	☐ Yes ☐ No ☐ No		

NUMBER OF DEFICIENCIES NOTED: _____

REQUIREMENT	RESPONSE	COMMENTS (FOR OFFICE USE ONLY)	CORRECTIVE ACTION
E. SUPERVISION			
1. The agency employs a supervisor at the ratio of one supervisor for every 8 eight case managers. (Check CAMIS agency print-out for case load size) (Section 6-16: IV-C)	☐ Yes ☐ No		
2. The case management supervisor(s) provides face to face supervision with each case manager at least once per week. (Section 6-14: IV-B, 2a & 3)	☐ Yes ☐ No		
3. The case management supervisor(s) conducts a supervisory review of 10% of each case manager's records per month. (Section 6-15: IV-B, 2d & 3)	☐ Yes ☐ No		
4. Each case manager has an annual evaluation by supervisor. (Section 6: IV-B)	☐ Yes ☐ No		
F. ORIENTATION AND TRAINING			
1. The agency insures that each case manager and case manager supervisor completes 40 hours of annual training.(Section 6-10: III-B & C)	☐ Yes ☐ No		
2. The agency insures that each case manager and case management supervisor completes all DHH mandated training as required. (Section 3-1: V-E 1, 2) (Section 3: V-R) (Section 6: III-A, B, C, & D) (Section 6: III-E)	☐ Yes ☐ No		
G. CONTINUOUS QUALITY IMPROVEMENT			
1. The agency has implemented a continuous quality improvement plan. (Section 3: V-F) (Section 9: I-E) ★	☐ Yes ☐ No		

NUMBER OF DEFICIENCIES NOTED: _____

REQUIREMENT	RESPONSE	COMMENTS (FOR OFFICE USE ONLY)	CORRECTIVE ACTION
H. RFP - CONTRACT REQUIREMENTS ★			
1. The agency has on file a signed contract.	☐ Yes ☐ No ☐ N/A		
2. The agency maintains on file a copy of it's subcontract agreements.	☐ Yes ☐ No ☐ N/A		
3. The agency has a plan to monitor subcontractors.	☐ Yes ☐ No ☐ N/A		
4. The agency provides the recipient freedom of choice of service providers.	☐ Yes ☐ No ☐ N/A		
5. The agency monitors each service provider quarterly.	☐ Yes ☐ No ☐ N/A		
6. The agency maintains records of the quarterly monitoring of the service provider that is signed and dated by the case manager	☐ Yes ☐ No ☐ N/A		
7. The agency employs a full time project manager.	☐ Yes ☐ No ☐ N/A		

NUMBER OF DEFICIENCIES NOTED: _____

PERSONNEL RECORDS CONTAIN: (Write name, title and start date in each block)						
1. Application/Resume' (Section 8: III-B1)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Driver's license (Section 8: III-B3)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Proof of auto insurance (Section 8: III-B3)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Diploma/transcript (Section 8: III-B5)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Verification of experience (Section 8-8: III-B1)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Begin dates/termination dates (Section 8: III-B1)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Annual evaluations by supervisor (Section 8: III-B6)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Salary documented (Section 8: III-B7)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Fingerprinting/Criminal History Check (State Law Requirement) (Section 8: III B-4) (N/A for elderly)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

NUMBER OF DEFICIENCIES NOTED: _____

TRAINING REQUIREMENTS (Write name, title, and start date in each block)						
1. Has each new employee completed 8 hours of agency orientation within five (5) working days? **(Section 6: III-A 1a & C)**	☐ Yes ☐ No ☐NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
2. Has each new employee received a minimum of 8 hours of orientation training specific to the target population within 5 working days? **(Section 6: III-A 1b)**	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
3. Has each new employee that does not have documented training completed the additional 16 hours of target population training during the first 90 days of employment? **(Section 6: III-A2)**	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
4. Has each case manager/supervisor completed 40 hours of annual training? **(Section 6: III-B, C, & D)**	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
5. Has each new employee attended the mandatory training provided by DHH? **(Section 6: III-E)**	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA

NUMBER OF DEFICIENCIES NOTED: _____

TRAINING REQUIREMENTS (Write name, title, and start date in each block)						
6. Specific Waiver elderly requirement: Do all case managers with Medicaid waiver cases have one year paid professional, post-degree, direct work experience in a human service related field. (Section 6: I A1)	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
PERSONNEL CORRECTIVE ACTION						

TOTAL NUMBER OF DEFICIENCIES NOTED: _____

This agency has been reviewed and
☐ meets the requirements as outlined above.
☐ does not meet the requirements as outlined above.

Reviewer:	Title:	Date:

The agency has submitted a corrective action plan
☐ and now meets the requirements as outlined above.
☐ and correction plan was not implemented as described and requirements are not met.
☐ and is not approved.

Reviewer:	Title:	Date:

COMMENTS:

CORRECTIVE ACTION PLAN SUBMITTED BY : _____ DATE: _____

Report for Capacity

Agencies must complete this form on all "Key Personnel" (Onsite Project Manager, Case Manager Supervisors, and Case Managers). This information will identify the agency's recipient capacity. The report shall be submitted to Judy Baker, BCSS Case Management Program Administrator, 446 North 12th Street, Baton Rouge, La 70802-4613.

Agency Name	
Provider Number	DHH Region#

Employee's Name:
Employee's Title Under Medicaid:

Complete the following if this employee carries a caseload (include the supervisors etc. that carry partial caseloads):

Total caseload Size_____	# of Medicaid:_____	# of Non-Medicaid_____
List the Medicaid Populations Served:		
List the Non-Medicaid Populations Served:		

Contractors must list all responsibilities of Key Personnel (Onsite Project Manager, Case Manager Supervisors, and Case Managers) related to other contracts/obligations and the estimated percent of time spent on these other duties (if other than caseload).

Is this employee a "Key Person" in other contracts?		
If yes, please list each contract and the following:		
Contract Name	Job Title for that Contract	estimated % of time
Job Duties (other than case management caseload)		
Contract Name	Job Title for that contract	estimated % of time
Job Duties (other than case management caseload)		

_____ _____

Agency's Authorized Representative's Signature Date

REVISED 07/19/01

CASE MANAGEMENT CHOICE and RELEASE OF INFORMATION FORM

DHH Region

To the consumer: Please fill out Sections 1, 2 and 3 of this form and return it as soon as possible to:

Statistical Resources, Inc. Case Management
11505 Perkins Road, Suite H
Baton Rouge, LA 70810
Fax: (225) 767-0502

Consumer's Name: _____ Physical Address: _____

Telephone Number: (____) ____-_____ Social Security Number: ____-___-_____

Medicaid Number: _____ Date of Birth: ___/___/_____

Section 1: Choice of Waiver Services

I understand that I have the right to choose between institutionalization and waiver services. I have opted for waiver and case management services.

For Information Only

_____ _____

Signature of Recipient / Legal Guardian Date

Section 2: Case Management Freedom of Choice - DHH Region 4

The state has contracted with several case management providers in your area. Please choose a provider from among these agencies. We ask that you number your choices. Please write 1 (one) in the box by your first choice and write 2 (two) in the box by your second choice. If your first choice is full, you will be linked to your second choice if they are not full. You will be linked for a 6-month period, after which you have the option of changing agencies.

- ❑ Agency 1
- ❑ Agency 2
- ❑ Agency 3
- ❑ Ventilator Assisted Care Program of Children's Hospital (**To make this choice, the recipient must be ventilator dependent, 21 and under, and meet the requirements of the program)**

Do Not Duplicate

_____ _____

Signature of Recipient / Legal Guardian Date

Section 3: Release of Information

I hereby authorize the release of any information that is pertinent to my care to the Case Management Agency that I have been assigned to. My permission to release this information will expire in one year.

_____ _____

Signature of Recipient / Legal Guardian Date

Section 4: Transfer of Records (For Agency Use Only)

Signatures by both Transferring Agency and Receiving Agency are required for the Transfer of Records to be finalized. Indicate which of the following required documents have been transferred. To obtain the records on this recipient please contact: _____

Address_____ Phone # _____

- ❑ 1. Discharge 148
- ❑ 2. Form 142
- ❑ 3. 18 LTC
- ❑ 4. 51NH
- ❑ 5. CPOC with MR/DD 14
- ❑ 6. Six months progress notes
- ❑ 7. Waiver slot letter (if not certified)
- ❑ 8. Social Evaluation
- ❑ 9. 90-L

_____ _____

Transferring Agency (Signature Required) Date Receiving Agency (Signature Required) Date

SRI DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE RECIPIENT IS IN THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.

FOC FORM MAY VARY FOR DIFFERENT POPULATIONS - CHECK WITH YOUR REGIONAL OFFICE

EPSDT Target Population
Client Reentering Case Management Program

(Recipient must have been Prior Authorized previously)

Date of Request: ___ / ___ /_____

Agency Name: _____

Agency Region: _____

Recipient Name: _____
(Please Print)

Recipient SSN Number: _____ - ____ - _____

Recipient Date of Birth: __ __ / __ __ / __ __ __ __

Medicaid Number: _____

Date of Re-Entry: __ __ / __ __ / __ __ __ __

_____ _____
Signature of Requesting Party Date

Please mail request to:

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

SRI DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE CONSUMER IS IN THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.

CASE MANAGEMENT AGENCY

CONTACT INFORMATION

DHH REGION_____**AGENCY NAME**_____

NAME OF STAFF PERSON RESPONSIBLE FOR CONDUCTING BUSINESS WITH DHH (This representative shall be named on the Board Resolution). Please note that all correspondence and directives from DHH regarding the contract and case management services will be sent to this person at the address below and they will be responsible for notifying the Onsite Project Manger of all information.

Name_____Title_____

Phone_____FAX_____

E-Mail Address_____

Street Address (for Fed. Ex. Correspondence etc.)_____

_____

Mailing Address if different_____

ONSITE INFORMATION IF DIFFERENT FROM ABOVE

Onsite Project Manager_____

Street
Address/City_____

Phone#_____FAX #_____

E-Mail_____

_____ _____

Date **Signature**

It is the Agency's responsibility to notify the DHH Case Management Program Administrator of any changes.

REVISED 07-19-01

Louisiana Department of Health and Hospitals

BUREAU OF COMMUNITY SUPPORTS AND SERVICES
COMPREHENSIVE PLAN OF CARE

TYPE: ❑ INITIAL ❑ ANNUAL ❑ PROVISIONAL

PROGRAM : WAIVER: ❑ ADHC ❑ E/DA ❑ MR/DD ❑ PCA ❑ CHILDREN'S CHOICE

OTHER: ❑ EPSDT TARGETED CASE MANAGEMENT ❑ NHV

PERSON'S NAME	DOB	OTHER CONTACT NAME:
SOCIAL SECURITY NUMBER:		
MEDICAID NUMBER & CARD CONTROL NUMBER		RELATIONSHIP
ADDRESS		ADDRESS (If different)
CITY / STATE / ZIP		CITY / STATE / ZIP
PHONE		PHONE
CASE MANAGEMENT AGENCY		PROVIDER NUMBER
ADDRESS OF CASE MANAGEMENT AGENCY		CONTACT PERSON
CITY / STATE / ZIP		TELEPHONE NUMBER

SEX: ❑ MALE ❑ FEMALE RACE: ❑ BLACK ❑ WHITE ❑ HISPANIC ❑ ASIAN ❑ OTHER

EDUCATION: ❑ ATTENDS SCHOOL ❑ HOMEBOUND ❑ 9 MONTHS ❑ 10 MONTHS ❑ N/A

LEGAL STATUS: ❑ MINOR ❑ INTERDICTED ❑ POWER OF ATTORNEY ❑ COMPETENT MAJOR ❑ OTHER_____

GUARDIAN _____ ADDRESS: _____ CONTACT NUMBER: _____

MR: ❑ MILD ❑ MODERATE ❑ SEVERE ❑ PROFOUND ❑ OTHER

ADAPTIVE FUNCTIONING: ❑ MILD ❑ MODERATE ❑ SEVERE ❑ PROFOUND ❑ OTHER AMBULATION: ❑ YES ❑ NO

SIL: ❑YES ❑ NO 24 HOUR SERVICES: ❑ YES ❑ NO MOBILE WITH ASSISTIVE DEVICES: ❑YES ❑ NO

SELF-EVACUATE: ❑ YES ❑ NO IF NO, INDIVIDUALIZED EVACUATION PLAN IS ATTACHED: ❑ YES ❑ NO

WILL RESIDENCE CHANGE WITH WAIVER PARTICIPATION? ❑ YES ❑ NO

IF YES, PROPOSED LIVING ADDRESS:_____

ARE THERE MULTIPLE RECIPIENTS IN THE HOME? ❑ YES ❑ NO IF YES, HOW MANY?_____

ARE ANY PAID CAREGIVERS RELATED TO RECIPIENT? ❑ YES ❑ NO DO PAID CAREGIVERS LIVE WITH RECIPIENT? ❑ YES ❑ NO

FOR BCSS USE ONLY:

High Risk Recipient: ❑ YES ❑ NO (If yes, BCSS will add to High Risk Tracking)

CPOC Begin Date:_____ CPOC End Date: _____

I. RECIPIENT PROFILE

A. HEALTH STATUS

1. **PHYSICAL:**

2. **MEDICAL DIAGNOSIS/CONCERNS:**

3. **PSYCHIATRIC/BEHAVIORAL CONCERNS:**

B. MEDICATIONS (Include prescribed meds, OTC meds that are given on a daily schedule, medical procedures) List any meds recipient is allergic to:

MEDICATIONS/ MEDICAL PROCEDURES	DOSE	ROUTE	FREQUENCY	TO BE ADMINISTERED/ ASSISTED BY (List Who & if Physician Delegation Needed)

C. NATURAL SUPPORTS: (List family, friends, and other community resources involved in supporting the recipient on a frequent basis).

D. ADAPTIVE BEHAVIOR FUNCTIONING: (Address the current functional status of the recipient in the follow ing areas):

1. **Health and Safety:**

2. **Self-Care:**

3. **Home Living:**

4. **Communication:**

5. **Relationships:**

6. **Community Use:**

7. **Leisure:**

8. **Vocational/Educational:**

E. HABILITATION GOALS/NEEDED SUPPORTS: (Outcome Based)

1. HEALTH AND SAFETY:

2. SELF-CARE:

3. HOME LIVING:

4. COMMUNICATION:

5. RELATIONSHIPS:

6. COMMUNITY USE:

7. LEISURE:

8. VOCATIONAL/ACADEMIC:

NAME:_____ Program Type: _____ CPOC Begin Date:_____ CPOC End Date:_____

II. CPOC: SERVICE NEEDS

UTILIZE THIS FORM TO COMPLETE THE CASE MANAGEMENT AND PROVIDER PLAN OF CARE. USE THE LETTER TO DISTINGUISH EACH SERVICE AREA. THIS FORM SHEET MAY BE DUPLICATED AS NECESSARY.

SERVICES:

A. CASE MANAGEMENT
B. PERSONAL CARE ATTENDANT
C. RESPITE
D. RESIDENTIAL HABILITATION
E. SUBSTITUTE FAMILY CARE
F. DAY HABILITATION
G. HABILITATION SUPPORTED EMPLOYMENT
H. PRE-VOCATIONAL HABILITATION
I. ENVIRONMENTAL MODIFICATION
J. PERSONAL EMERGENCY RESPONSE
K. ASSISTIVE DEVICES
L. FAMILY/VOLUNTEER
M. NON-MEDICAID RESOURCES
N. SOCIAL SERVICES
O. MEDICAL SERVICES-NURSING
P. ACTIVITIES (e.g., GAMES, CRAFTS, READINGS)
Q. DIETARY
R. OTHER RESOURCES

GOALS OR NEEDED SUPPORT	SERVICE AREA(S)/ FREQUENCY	ANTICIPATED OUTCOME	REVIEW / RESOLUTION DATE

Name:_____ Program Type:_____ CPOC Begin Date:_____ CPOC End Date:_____

II. CPOC: SERVICE NEEDS

UTILIZE THIS FORM TO COMPLETE THE CASE MANAGEMENT AND PROVIDER PLAN OF CARE. USE THE LETTERS ON PAGE 5 TO DISTINGUISH EACH SERVICE AREA. THIS FORM SHEET MAY BE DUPLICATED AS NECESSARY.

GOALS OR NEEDED SUPPORT	SERVICE AREA(S)/ FREQUENCY	ANTICIPATED OUTCOME	REVIEW / RESOLUTION DATE

Name:_____ Program Type:_____ CPOC Begin Date:_____ CPOC End Date:_____

III. CPOC: TYPICAL WEEKLY SCHEDULE

Specify in the appropriate time slot the services provided by Medicare/Medicaid, insurance carriers or other local, state, or federally funded services. Waiver services are to supplement, rather than replace, family and non-medical services.

TIME	MON	TUES	WED	THUR	FRI	SAT	SUN
6:00AM							
7:00AM							
8:00AM							
9:00AM							
10:00AM							
11:00AM							
NOON							
1:00PM							
2:00PM							
3:00PM							
4:00PM							
5:00PM							
6:00PM							
7:00PM							
8:00PM							
9:00PM							
10:00PM							
11:00PM							
12:00AM							
1:00AM							
2:00AM							
3:00AM							
4:00AM							
5:00AM							

COMMENTS:

Name:_____ Program Type:_____ CPOC Begin Date:_____ CPOC End Date:_____

III.a. CPOC: ADDITIONAL SCHEDULE (FOR VACATION, HOLIDAYS, ETC)

(Make copies as needed)

Specify in the appropriate time slot the services provided by Medicare/Medicaid, insurance carriers or other local, state, or federally funded services delivered during the school vacation time and during school holidays. Waiver services are to supplement, rather than replace, family and non-medical services.

TIME	MON	TUES	WED	THUR	FRI	SAT	SUN
6:00AM							
7:00AM							
8:00AM							
9:00AM							
10:00AM							
11:00AM							
NOON							
1:00PM							
2:00PM							
3:00PM							
4:00PM							
5:00PM							
6:00PM							
7:00PM							
8:00PM							
9:00PM							
10:00PM							
11:00PM							
12:00AM							
1:00AM							
2:00AM							
3:00AM							
4:00AM							
5:00AM							

COMMENTS:

Name:_____ Program Type:_____ CPOC Begin Date:_____ CPOC End Date: _____

IV.A. CPOC: REQUESTED WAIVER SERVICES-Typical Week Schedule

List the recipient's requested serv ices as described in the CPO C, Section III

PROVIDER NAME	PROVIDER NUMBER	SERVICE TYPE	PROCEDURE CODE	# OF UNITS	COST/ UNIT	MONTHLY COST	START DATE	END DATE
					TOTAL ➡			

DAILY SERVICE TOTALS

SERVICE TYPE (LIST THE SERVICE AND PROCEDURE CODE FROM COLUMNS 3 AND 4 ABOVE)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	WEEKLY TOTAL (Equals # of Units per service, in Column 5 Above)
								➔
								➔
								➔
								➔
								➔
								➔
								➔
								➔
								➔

Name:_____ Program Type:_____ CPOC Begin Date:_____ CPOC End Date: _____

Signature/Title BCSS RO Representative: _____ **Date:**_____

BCSS -

IV.B. CPOC: REQUESTED WAIVER SERVICES-Vacation/Holidays, Summer School Closure, etc.

List the recipient's requested serv ices as described in the CPO C, Section III. a.

PROVIDER NAME	PROVIDER NUMBER	SERVICE TYPE	PROCEDURE CODE	# OF UNITS	COST/ UNIT	MONTHLY COST	START DATE	END DATE
					TOTAL ➡			

DAILY SERVICE TOTALS

SERVICE TYPE (LIST THE SERVICE AND PROCEDURE CODE FROM COLUMNS 3 AND 4 ABOVE)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	WEEKLY TOTAL (Equals # of Units per service, in Column 5 Above)
								➔
								➔
								➔
								➔
								➔
								➔
								➔
								➔
								➔

Name:_____ **Program Type:**_____ **CPOC Begin Date:** _____ **CPOC End Date:**_____

Signature/Title BCSS RO Representative:_____ **Date:**_____

V. CPOC: PARTICIPANTS

PARTICIPANTS MUST SIGN THAT THEY PARTICIPATED IN THE PLANNING MEETING AND AGREE WITH THE PLAN:

PLANNING PARTICIPANTS	TITLE

_____ _____

Case Manager/Responsible Discipline Signature Date

_____ _____

Case Management Supervisor Signature Date

I have reviewed the services contained in this plan. I choose to accept this plan and the serv ices described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify the case manager of any change in my status which might affect the effectiveness of this program. I further agree to notify the case manager of any change in my income which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the serv ices identified in this support plan.

I understand that if I disagree with any decision rendered regarding the approv al of this plan, I have the right to an informal discussion with BCSS and/or a fair hearing by the DHH Appeals Bureau within 10 days of the approved/denied decision. I can contact my BCSS Regional Office for an informal discussion. I understand that a Fair Hearing with the DHH Appeals Bureau may be requested by contacting the DHH Bureau of Appeals, P.O. Box 4183, Baton Rouge, LA 70821-0165.

_____ _____

Person's Signature/Guardian Signature Date

_____ _____

Witness/Professional Title/Agency Date

VII. CARE PLAN ACTION

Name:_____ Program Type:_____

Date complete CPOC received in BCSS RO:_____

The CPOC meets the identified needs of the recipient: APPROVED DENIED

Without the services available through this Waiver, the recipient would qualify for institutional care. YES NO

Approved CPOC Begin Date:_____ Approved CPOC End Date:_____

COMMENTS:

Signature/Title of BCSS Representative:_____ Date:_____

Louisiana Department of Health and Hospitals
Bureau of Community Supports and Services

COMPREHENSIVE PLAN OF CARE

COMPREHENSIVE PLAN OF CARE INSTRUCTIONS

I. Recipient Demographics

II Recipient Profile

A. Health Status
B. Medication/Procedures
C. Natural Supports
D. Adaptive Behavior Functioning
E. Habilitation Goals and Needed Supports

III. CPOC Service Needs

A. Column 1: Goals and Needed Support
B. Column 2: Service Area/Frequency
C. Column 3: Anticipated Outcome
D. Column 4: Review/Resolution Date

IV. CPOC Service Delivery Schedule

A. Typical Weekly Schedule
B. Additional Schedule (For Vacation, Holidays, Etc.)

V. CPOC Requested Waiver Services

A. Typical Weekly Schedule
B. Additional Schedule (for Vacation, Holidays, Etc.)

VI. CPOC Participants

VII. Care Plan Action

NURSE HOME VISITATION PROGRAM

INSTRUCTIONS FOR THE COMPREHENSIVE PLAN OF CARE

GENERAL PURPOSE:

The CPOC is designed to briefly summarize important information so that it can be quickly reviewed and considered in evaluating the need for proposed services and supports. Obviously, information critical to the recipient's health and safety or that of others should be more extensively documented in other materials. As there are four Waiver programs, the information requested may vary in relevance for a given individual.

The CPOC is intended to be user friendly, person specific, and flexible to varying approaches, orientations, and programs. The goal is to provide services and supports in a recipient focused, cost effective and accountable manner. The CPOC should always emphasize the recipient's personal goals and that of their family in order to maintain the waiver as a viable and appealing alternative to institutional care. **Only information relevant and applicable to justifying service requests for the applicant must be provided.**

This CPOC format is to be used with all BCSS Waiver Programs- MR/DD Waiver, Elderly and Disabled Adult Waiver, Adult Day Health Care, Children's Choice; and EPSDT Targeted Case Management, and Nurse Home Visitation Program. Refer to the EPSDT Targeted Case Management and Nurse Home Visitation sections for additional instructions on use of this CPOC format.

COMPREHENSIVE PLAN OF CARE:

I. Recipient Demographics

This initial portion of the CPOC requires the ID Team to provide current information on the recipient, including name, address, Medicaid/Medicare and Card Control Number (16 digit swipe card number), guardian's name and address, and the case management agency's name and address. The next section requests a description of the current and proposed living situation, and other information such as race, sex, education, legal status, and adaptive functioning and needs.

The last item is for "BCSS Use Only". Determine whether the individual meets the criteria for High Risk Status and indicate here. If yes is checked, the individual will be

added to the BCSS High Risk list for monitoring purposes.

II. Recipient Profile

This section summarizes important aspects of the recipient's health status, medication needs, natural supports, adaptive functioning and needed supports. Specific components of the recipient profile are described below:

A. Health Status

This section describes the recipient's physical and medical status and any behavioral or psychiatric concerns.

1. Physical Status

   This section describes the recipient's functional abilities in vision, hearing, mobility, use of arms/hands, and any need for assistive devices, as relevant.

2. Medical Diagnosis/Concerns

   This section describes the recipient's medical status, including all current medical diagnoses, description of all current health problems and needs. The information comes from the 90-L and other data documenting the recipient's health history and medical needs.

3. Psychiatric/Behavioral Concerns

   This section requires a description of the recipient's psychiatric status, diagnoses, and significant behavior concerns. Descriptions of recipient behavior concerns should provide relevant information on situational variables that affect the occurrence of the behavior. Any relevant history regarding suicidal or homicidal ideation, intent, or attempt as well as history of elopement, aggression, and inappropriate sexual behavior should be provided. Also, information on effective behavioral interventions and skills training should be detailed in accompanying documentation. **Attach a copy of the behavioral support plan to the CPOC document.**

B. Medication/Procedures

This section lists all prescribed and over the counter medications, and/or medical procedures. Include medication dosage, route of administration, frequency of

administration and individual or service provider responsible for administration. Include procedure descriptions (e.g.,dressing changes, tube feeding, breathing treatment, enemas), procedure frequency, and person/agency responsible for performing the procedures. For example, state "family member", "personal care attendant", "nurse", etc. Do not use proper names. Include documents that justify physician delegation and/or CMA certification. All medications that result in an allergic reaction to the recipient should be listed.

C. Natural Supports

This section is intended to document and encourage the utilization of family and community supports. Of course, family and community supports may be limited depending on the individual. However, by law, Medicaid services are to be provided after other sources of funding and support have been utilized and should be explored and encouraged. Utilization of non-Medicaid services and supports can reduce duplication of service delivery.

D. Adaptive Behavior Functioning

This section provides very specific information of the recipient's current situation in various areas of adaptive functioning. This information is taken directly from the psychological evaluation, social history, and from those individuals familiar with the recipient. This section should specifically document the recipient's functional capabilities. Below are definitions of each area.

1. Health and Safety: Abilities related to maintenance of one's health, basic safety considerations (e.g., using seat belts, crossing streets, interacting with strangers, etc.), and regular physical and dental check-ups. The recipient's ability to effectively respond to an emergency and self-evacuate must be documented.

2. Self-Care: Abilities involved in toileting, eating, dressing, hygiene, and grooming must be documented.

3. Home-Living: Abilities related to functioning within a home, which include clothing care, housekeeping, property maintenance, food preparation, planning and budgeting for shopping, home safety, and daily scheduling.

4. Communication: Abilities related to the comprehension and expression of information through symbolic behaviors (e.g., spoken word, written word, sign language) or nonsymbolic behaviors (e.g., facial expression, body

movement, touch, gesture). A specific statement indicating whether the recipient is primarily verbal or non-verbal should be included.

5. Relationships: Abilities in the social area related to having interactions with others, developing and maintaining friendships and relationships, recognizing and expressing feelings, regulating one's own behavior, and controlling impulses, as appropriate to various social situations.
6. Community Use: Abilities related to the appropriate use of community resources, including grocery shopping, general shopping, ordering and eating in a restaurant, attending church or synagogue, using public transportation and public facilities.

7. Leisure: Abilities related to the development of a variety of leisure and recreational interests that reflect personal preferences and choices.

8. Vocational/Academic: Vocational abilities are related to holding a part or full-time job in the community in terms of specific job skills, appropriate social behavior, and related work skills. Managing money earned would also be included in this area. Academic abilities include cognitive abilities and skills related to learning at school that also have direct application in one's life.

E. Habilitation Goals and Needed Supports

This section is used to describe supports, in terms of assistance or training, needed for the recipient to function in the community. The recipient's goals and preferences should always be included in any decision making regarding training or needed supports. Training goals should be written in a way that changes in personal outcomes can be measured and determined. There are some situations in which skills training is not relevant as the recipient is unlikely to ever learn to perform the skill such as a quadriplegic who is unlikely to walk. In these cases, the recipient would need support to complete the task. Needed supports should be written so that the amount and type of support given is clearly defined.

III. CPOC Support/ Service Needs

The Service Needs utilizes information from all other sections to determine the goals or needs of the recipient, service areas and frequency of service delivery, and anticipated outcomes. It is to include all medical and social needs identified in the CPOC planning process, as well as waiver services, and whether services are being received or linked.

This section shall also include statements in the CPOC to address the following (as appropriate for the age group):

A. Recipient notified of Medicaid Services that may be applicable (Ages 21 and over).

B. Recipient notified of EPSDT Services (Under age 21).

C. Recipient notified of EPSDT/PCS Services (Under 21 & not in MR/DD Waiver).

D. Recipient referred for KIDMED Services (Under age 21).

A statement shall be made noting if the recipient is interested in and has been referred to the above-noted services or if the recipient has refused/not interested in these services.

A. Column 1: Goals and Needed Support

This section is taken directly from Recipient Profile data, items A-E. The suggested order for the requested services is: case management, medical needs, psychiatric / behavioral needs, and needed supports. Item E is specifically important as it describes what support, assistance, or training is needed and in the specific areas as outlined.

B. Column 2: Service Area/Frequency

The service area specifies who will provide the service (as indicated by the letters A-R) for addressing the recipient's training goals, medical or behavioral needs, or other needed supports. It is important to utilize (and list) family, community, and non-Medicaid sources of service provision whenever possible.

Included in this column is a description of the frequency of service delivery the provider will use to meet the recipient's need. For example, "assist with bathing once daily and hair washing three times weekly to be performed by family and the PCA."

C. Column 3: Anticipated Outcome

This section is used to outline the desired outcome of training or needed supports. This may reflect skill acquisition or may simply be a statement regarding the recipient's maintenance in the home and community with provided supports. For example, an elderly person who needs assistance with preparing their meals. The anticipated outcome may be that the person received assistance and had meals prepared by their PCA in a manner that was satisfactory to the person. Outcome

should answer the question as to "why" this service is needed and/or the benefit of the service provided.

D. Column 4: Review/Resolution Date

This section identifies the anticipated date of when the CPOC will be reviewed. The review will determine whether the recipient's needs have been adequately met and whether the services continue to be necessary. The CPOC must be reviewed at least quarterly and updated yearly.

IV. CPOC SERVICE DELIVERY SCHEDULES

A. Typical Weekly Schedule

This is an hourly schedule for listing Medicaid, Medicare, private insurance, and other local, state, or federally funded services provided throughout the week. **This page is simply designed to provide a visual overview of service delivery during a typical week.** The intent of the service delivery schedule is to help reduce redundant or unnecessary service delivery. Services should be provided in accordance with what is needed, no more, no less. Simply list the source of service provision when applicable. In addition, for waiver programs such as ADHC, simply marking in the time the recipient receives this service may be sufficient. The service delivery schedule is not to be used for daily monitoring of service delivery or monitoring of recipient's daily activities.

B. Additional Schedule (For Vacation, Holidays, Etc.)

This schedule will be used to identify those days that the recipient is out of school for summer vacation, school holidays or holidays from work programs. This is necessary due to the proposed prior authorization (PA) system in Medicaid. A copy of the actual school schedule or Day Hab schedule should be attached showing the dates when the holidays occur.

V. CPOC REQUESTED WAIVER SERVICES

A. Typical Weekly Schedule

The top section lists the recipient's required Medicaid funded services as described in the CPOC. All information should be taken from the Service Plan and the Weekly Schedule. **It is very important to have the correct provider number indicated on the form. This number will affect not only the data input into the PA system, but billing and reimbursements.**

The bottom section lists the services to be delivered on a daily basis. Service Type (i.e., PCA, Respite, etc.) and the corresponding Procedure Code will be taken from the third and fourth columns from the top section of this page. The exact number of hours of service to be delivered for a particular day should be listed under the appropriate day. The total number of hours of each service for the week will be listed in the last column.

The BCSS Regional Office Representative reviewing and approving this plan must sign and date this section.

B. Additional Schedule (For Vacation, Holidays, Etc.)

The top section identifies the additional billing schedule when the recipient's schedule reflects days of summer school vacation, school holidays, or work holidays. **It is very important to have the correct provider number indicated on the form. This number will affect not only the data input into the PA system, but billing and reimbursements.**

The bottom section lists the services to be delivered on a daily basis for the additional billing schedule. Service Type (i.e., PCA, Respite, etc.) And the corresponding Procedure Code will be taken from the third and fourth columns from the top section of this page. The exact number of hours of service to be delivered for a particular day should be listed under the appropriate day. The total number of hours of each service for the week will be listed in the last column.

The BCSS Regional Office representative reviewing and approving this plan must sign and date this page.

VI. CPOC PARTICIPANTS

This section identifies all participants who take part in the development of the CPOC. All participants should sign their name and include their title. By signing this form, the participant indicates agreement with the plan as written. The case manager or responsible discipline and the case manager supervisor will sign and date the form. The boxed section is for the recipient and/or guardian to sign and date. By signing this form, the recipient and/or guardian indicates they have an understanding of their responsibilities. In addition, they understand their alternatives as explained during the meeting and addressed on the CPOC. After the recipient and/or guardian signs, a witness signature is needed.

VIII. CARE PLAN ACTION

This section indicates approval or denial of the CPOC, and whether it meets the identified needs of the recipient. Without these services, the recipient would qualify for ICF/MR care. The BCSS Waiver Operations representative will complete this section, add any comments if necessary, and sign and date the bottom of the form.

EPSDT TARGETED CASE MANAGEMENT:

The following pages of the CPOC must be completed for EPSDT Targeted Case Management:

Pages 1, 2, 5, 6, 11

NURSE HOME VISITATION:

The Nurse Home Visit Program will complete the following pages of the CPOC for submission to BCSS:

Pages 1, 2, 5, 6, 11

EXIT CONFERENCE
ACKNOWLEDGMENT STATEMENT

Recipient:_____
Provicer:_____

I, hereby, acknowledge the following:

_____I have been given the opportunity to provide additional information, as necessary, regarding areas of concern identified at the exit conference for the survey on_____.

_____I have received a copy of the recipient identifier list. (If Applicable)

_____	_____
AGENCY REPRESENTATIVE	SURVEYOR
_____	_____
DATE	DATE

REVISED 07-19-01

Infant and Toddler
Medicaid Eligibility Re-Established

(Recipient must have been Prior Authorized previously)

Date of Request: ___ / ___ /_____

Agency Name: _____

Agency Region: _____

Recipient Name: _____
(Please Print)

Recipient SSN Number: _____ - ____ - _____

Recipient Date of Birth: __ __ / __ __ / __ __ __ __

Medicaid Number: _____

Effective Date of Eligibility: __ __ / __ __ / __ __ __ __

_____ _____
Signature of Requesting Party Date

Please mail request to:

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

SRI DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE CONSUMER IS IN THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.

BHSF Form 148
Rev. 11/01
Prior Issues Obsolete

NOTIFICATION OF ADMISSION, STATUS CHANGE OR DISCHARGE

Provider Name:	Telephone #:	Medicaid Vendor #:

I. RECIPIENT INFORMATION

A. Recipient's Name:		SS #:	Date of Birth:
B. Address (City, State, Zip Code & Parish):		C. Responsible Party/Curator:	
		Address (City, State, Zip Code & Parish):	
Telephone #:	Race: Sex:		
Medicare #:		Relationship:	Telephone #:

D. Medicaid Eligible: ☐ Yes ☐ No If yes, Medicaid ID #:

E. Does recipient wish to apply for Medicaid? ☐ Yes ☐ No Application Date (if later than admission):

Type of Admit: (check one)

II. ADMISSION INFORMATION

☐ A. New Admit Date:	☐ B. Re-admit Date:	☐ C. Transferred on _____ From:	☐ D. Medicare/ Medicaid Co-Pay Effective Date:

E. Source of Admission: ☐ Home ☐ Hospital ☐ Nursing Home ☐ ICF/MR ☐ Other _____

F. Payment Source: ☐ Private ☐ Medicare ☐ Medicare/Medicaid ☐ Medicaid ☐ VA (contract _____)

G. Level of Care recommended on 90-L:
☐ IC II ☐ IC I ☐ SN: ☐ TDC ☐ ID ☐ NRTP (☐ Complex ☐ Rehab) ☐ ICF/MR ☐ HOSPICE

Type of Change: (check one)

III. STATUS CHANGE

A. ☐ On acute care hospital/home leave but not discharged. Medicaid billing stopped on _____
(Do not remove from Turn Around Document)

B. ☐ 1. Admitted to Medicare Skilled unit Hospital/Facility (circle one). Medicaid billing stopped on _____
(Remove from Turn Around Document)
☐ 2. Co-payment effective _____

C. ☐ 1. Return to Medicaid bed. Medicaid billing re-started on _____
☐ 2. Conversion from Private Payment to Medicaid effective _____
☐ 3. Conversion from Medicare with Medicaid Co-Pay to Medicaid effective _____
☐ 4. Conversion to/from Hospice effective _____

D. ☐ Level of Care change effective _____
New Level of Care recommended on 90 L: ☐ IC II ☐ IC I ☐ SN: ☐ TDC ☐ ID ☐ NRTP (☐ Complex ☐ Rehab)

Type of Discharge: (check one)

IV. DISCHARGE INFORMATION

A. ☐ Discharged on _____ to _____ ☐ 1. Intend to return

B. ☐ Transferred to other Nursing Home/ICF-MR on _____ Name: _____	C. ☐ Died on _____

_____ _____
Signature of Administrator or Authorized Representative Date

ONSITE CONTRACT CASE MANAGEMENT AGENCY FORM

04/04/2002

REGION:	MONITORING UNIT STAFF: TELEPHONE NUMBER:
NAME OF AGENCY:	DATE OF ONSITE MONITORING:
NUMBER OF CASE MANAGERS EMPLOYED OR CONTRACTED:	
NUMBER OF SUPERVISORS EMPLOYED OR CONTRACTED:	

NO	YES		
		1.	Does Ratio of case Managers to Supervisors meet Medicaid Case Management Manual standards?
		2.	Does agency have a toll free number?
		3.	Does agency have a written process for use of number? Is it approved by the Case Management Program Director?
		4.	Does agency have a plan to monitor the response time to the recipient?
		5.	Does agency have a plan to increase staffing as more recipients are added? Will they be using part-time case managers? Is it approved by the Case Management Program Director?
		6.	Does agency have onsite operational computer equipment?
		7.	If agency is also a directed service provider, do they have a written plan to ensure that they will not serve the same recipient? Is it approved by Case Management Program Director?
		8.	If agency is sharing administrative duties with more than one Region in which they have a contract, is there a written plan available that demonstrates full coverage for each office? Is it approved by the Case Management Program Director?
		9.	Is there a copy of the RFP and amendments onsite?
		10.	Is there a draft manual with the amendment onsite?

Case No._____
Date:_____
No. of Deficiencies_____

PCA WAIVER PROVIDER MONITORING REPORT FORM
COMPLIANCE REQUIREMENT CHECKLIST
_____QUARTER _____YEAR

RECIPIENT NUMBER: REGION:	COMPANY NAME: CASE MANAGER: PHONE NUMBER:
NAME AND ADDRESS OF FACILITIES:	FACILITY DIRECTOR: PROGRAM DIRECTOR: PHONE NUMBER:
FACILITY MEDICAID PROVIDER NUMBER:	IS DSS SURVEY AVAILABLE FOR REVIEW? YES _____ NO _____
DOES THE FACILITY HAVE A CURRENT LICENSE ISSUED BY DSS? YES _____ NO _____ DATE OF EXPIRATION: LICENSE NUMBER: IS ADDRESS COMPLETE? YES _____ NO _____	WERE DEFICIENCIES PRESENT? YES_____ NO _____ IF DEFICIENCIES WERE NOTED, HAVE THEY BEEN CORRECTED? YES _____ NO _____

REQUIREMENTS	RESPONSE			DEFICIENCIES	CORRECTIVE ACTION
	YES	NO	N/A		
A. ADMINISTRATIVE					
1. THE AGENCY HAS A BOARD OF DIRECTORS AND A TABLE OF ORGANIZATION WITH NAMES, POSITIONS AND DESIGNATED LINES OF AUTHORITY.					
2. FORM 90L COMPLETED 90 DAYS PRIOR TO WAIVER SERVICE REQUEST. ANNUALLY THEREAFTER.					
3 . THE AGENCY HAS ADEQUATE COMMERCIAL AND GENERAL LIABILITY INSURANCE FOR THE PROTECTION OF CONSUMERS, STAFF, FACILITY, AND GENERAL PUBLIC.					
4. THE AGENCY HAS AN ANNUAL AUDIT.					

NUMBER OF DEFICIENCIES NOTED: _____

REQUIREMENTS	RESPONSE			DEFICIENCIES	CORRECTIVE ACTION
B. COMPLAINT PROCEDURE	**YES**	**NO**	**N/A**		
1. THE AGENCY HAS A COMPLAINT POLICY.					
2. THE AGENCY HAS AN ADEQUATE PROCEDURE TO ADDRESS COMPLAINTS.					
3. THE AGENCY HAS AN ABUSE/NEGLECT POLICY AND PROCEDURE.					
4. THE AGENCY IMPLEMENTS A PROCEDURE FOR RECEIVING AND RESOLVING COMPLAINTS.					
5. THE AGENCY MAINTAINS DOCUMENTATION FOR INCIDENT REPORTS/FINDINGS.					
C. CPOC COMPLIANCE					
1. THE AGENCY HAS A CPOC PLAN WHICH DESCRIBES THE SERVICES TO BE DELIVERED.					
2. THE CPOC PLAN IS APPROVED ANNUALLY.					
3. THE CPOC PLAN DESCRIBES STRATEGIES FOR COMPLETING THE DESIGNATED OUTCOMES. (*WHEN APPLICABLE)					
D. CASE MANAGEMENT REQUIREMENTS					
1. CASE MANAGEMENT IS BEING PROVIDED BY PCA AGENCY DESIGNATED QUALIFIED CASE MANAGER.					
2. CASE MANAGER DOCUMENTS PROGRESS NOTES MONTHLY.					
3. CASE MANAGER SUMMARIZES PROGRESS QUARTERLY.					
4. CASE MANAGER RECEIVES FACE-TO-FACE SUPERVISION.					
5. EACH CASE MANAGER HAS AN ANNUAL EVALUATION.					

NUMBER OF DEFICIENCIES NOTED: _____

REQUIREMENTS	RESPONSE			DEFICIENCIES	CORRECTIVE ACTION
E. STAFFING COMPLIANCE FOR DIRECT CARE STAFF	YES	NO	N/A		
1. THE AGENCY COMPLIES WITH STAFFING REQUIREMENTS: A. REVIEW PERSONNEL ROSTER 1. Drivers License 2. Criminal background check B. REVIEW TIME SHEETS C. IS ANYONE IN THE RECIPIENT'S FAMILY PROVIDING PAID SERVICES TO THEM?					
2. THE AGENCY DOCUMENTS COMMUNICATION BETWEEN THE DIRECT CARE WORKER AGENCY AND THE CASE MANAGER.					
F. BILLING COMPLIANCE FOR MEDICAID					
1. THE AGENCY MAINTAINS THREE MONTH OF TIME SHEETS FOR REVIEW.					
2. THE AGENCY MAINTAINS THREE MONTHS OF REMITTANCE ADVICE FOR REVIEW.					
3. THE TIME SHEETS MATCH THE CPOC.					
4. THE PROGRESS NOTES MATCH THE CPOC.					
5. THE BILLING DOCUMENTS MATCH TIME SHEETS.					
6. THE BILLING DOCUMENTS MATCH PROGRESS NOTES.					
7. THE TIME SHEET IS SIGNED BY STAFF.					
8. THE TIME SHEET IS SIGNED BY FAMILY.					

NUMBER OF DEFICIENCIES NOTED:_____

REQUIREMENTS	RESPONSE			DEFICIENCIES	CORRECTIVE ACTION
F. BILLING COMPLIANCE FOR MEDICAID	YES	NO	N/A		
9. THE PROVIDER RETAINS FOR AUDIT, COPIES OF TIME SHEETS.					
10. THE PROVIDERS RETAINS FOR AUDIT, COPIES OF PROGRESS NOTES (RETAIN AT LEAST 6 MONTHS PROGRESS NOTES).					
11. BILLING MATCHES HOURS AUTHORIZED APPROVED CPOC.					
G. RECORD REVIEW					
1. ALL ENTRIES AND FORMS DATED AND SIGNED.					
2. DOCUMENT IF ERROR CORRECTION PROCEDURE IS FOLLOWED.					
H. CONFIDENTIALITY					
1. REQUIREMENTS ARE MET.					
2. ARE THEY REVIEWING AND MONITORING THEIR OWN SERVICE PLAN?					

TOTAL NUMBER OF DEFICIENCIES NOTED:_____

PERSON (S) INTERVIEWED AND THEIR TITLE:

COMMENTS:

REVIEWER SIGNATURE:	**TITLE:**	**DATE:**
REVIEWER SIGNATURE:	**TITLE:**	**DATE:**

CORRECTIVE ACTION SUBMITTED BY: _____ _____

Signature **Date**

PRIOR AUTHORIZATION CHECKLIST
(Please Print Information)

Agency Name: _____

Agency Region: _____

Client Name: _____

Client SSN: _____

Client DOB: _____

Client Medicaid #: _____
Must have 13 digit Medicaid number and not the CCN Number

Program:

❒ **MRDD Waiver (New Client)**
- ○ CPOC Approval Page

MRDD Waiver (Transfer Client)
- ○ Freedom of Choice / Transfer of Records

❒ **Children's Choice Waiver (New Client)**
- ○ CPOC Approval Page
- ○ CPOC Budget Page

Children's Choice Waiver (Transfer Client)
- ○ 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 Waiver (New Client)**
- ○ CPOC Approval Page

Elderly Waiver (Transfer Client)
- ○ Freedom of Choice / Transfer of Records

❒ **EPSDT - Target Population (New Client)**
- ○ CPOC Approval Page

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

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

❒ **Nurse Home Visit**
- ○ MOTHER: Signed Freedom of Choice Form.
- ○ CHILD: Client data form with Medicaid Number written on the top right corner.

CASE MANAGEMENT MONITORING REPORT
RECIPIENT RECORD REVIEW FORM

CASE NUMBER:_____

☐ **MRDD WAIVER** ☐ **ELDERLY/ADULT WAIVER**

Agency Name:	**Case Manager:**
Recipient Number:	**Recipient Medicaid #:**

REQUIREMENT	RESPONSE			COMMENTS	CORRECTIVE ACTION
A. ELIGIBILITY	Y	N	NA*		
1. Annual documentation supports that the recipient meets eligibility requirements for the appropriate population.(Section 4, Section 5) a. MR/DD Waiver (Section 4, VI: D) (Section 5, I. A, 2) (Waiver Manual 22-23 and 22 -2-5) b. Elderly/Disabled Adult Waiver (Section 4 VI: E)					
2. The current approved CPOC Service Provider and Home Health Plan of Care (if applicable) are maintained in the recipient's record.					
3. Documentation is present that shows date of receipt of FOC letter. (Section 5, I A) (On new admissions only)					
4. Was the CPOC completed and submitted for medical and financial eligibility determined within 35 days of receipt of FOC letter. [Initials Packets Only] (Section 5: III, C) (initial only)					

NUMBER OF DEFICIENCIES NOTED: _____

* NA = NOT APPLICABLE

REQUIREMENT	RESPONSE			COMMENTS	CORRECTIVE ACTION
B. INTAKE	Y	N	NA*		
1. Interview was completed within three (3) working days of receipt of FOC at the case management agency. (Section 5: I, A, 1) (Initial only & new admissions)					
2. Consumer rights form was signed by recipient/guardian. (Section 5: I, A, 5, C) (Section 8: IV, B, e)					
3. Case management forms have been signed by recipient/guardian. (Section 5: II, E, 4) (Section 8: IV, B, e)					
C. ASSESSMENT/DIAGNOSIS AND EVALUATION (D&E)					
1. Psychological assessment has been completed. (Section 5, E, 1) MR/DD only (N/A for elderly)					
2. Assessments have been completed in recipient's home. (Section 5: II, A, B, C) If not in home, where?_____					
3. Assessment begins within 7 days of receipt of FOC and is completed within 30 days of referral. (Initial)					
* 4. Case management person centered support assessments addresses all relevant areas. (Section 5: II, C, D)					

NUMBER OF DEFICIENCIES NOTED: _____

* Applicable when training completed for personal outcomes and support strategies.

* NA = NOT APPLICABLE

REQUIREMENT	RESPONSE			COMMENTS	CORRECTIVE ACTION
C. ASSESSMENT/DIAGNOSIS AND EVALUATION (D&E) (CONT.)	Y	N	NA*		
5. Annual updates of 90L have been completed as required by the targeted population (MR/DD (Section 5: II, B, D (Elderly/Adult Waiver (Section 5, III, B, D)					
D. CPOC					
1. Are signatures on the CPOC present of planning participants? (Family, recipient, guardian, service provider staff, or other who know recipient) (Section 5: III, B, 5)					
* 2. CPOC is based on personal outcomes desired by the recipient/guardian and other information gathered in the case management person centered supports assessment. (MR/DD) (Section 5: III, A, 1, 2, a 2)					
3. Frequency of services to be provided is documented. (Section 5: III, B, 4)					
4. Location/setting of services to be provided is documented.					
5. CPOC is developed, signed and dated by case manger, CM supervisor, and recipient/guardian. (Section 5: III, B, 6)					
6. CPOC Programmatic Review is signed and dated by Waiver Specialist programmatic review. (Section 5: III, B, 6)					

NUMBER OF DEFICIENCIES NOTED: _____

* Applicable when training completed for personal outcomes and support strategies.

* NA = NOT APPLICABLE

REQUIREMENT	RESPONSE			COMMENTS	CORRECTIVE ACTION
D. CPOC (CONT.)	Y	N	NA*		
7. CPOC is reviewed, signed, and approved by DHCBW. (Section 5: III B, 6)					
* 8. Participation of recipient/guardian in identifying formal/informal support strategies is documented. (Section 5: III A, 2)					
* 9. CPOC assures interests/preferences of recipient/guardian as identified in the Social Assessment.(PCP document) (Section 5: III, B 1)					
* 10. Review and update of CPOC to ensure progress and reassess personal outcomes occurs quarterly. (Section 5, III, C, 2)					
E. MONTHLY PROGRESS NOTES					
1. Progress notes document contacts for use of natural and community-based supports. (Section IV, B, 3, b h)					
2. Progress notes document contacts made, by whom & for what case management activity. (Section 8-IV: B, 3, a, b) (Section 5, III, A, 2, a, 2)					
3. Progress notes support CPOC. (Section 8, IV, B, 3, b, c)					
* 4. Progress notes support personal outcomes. (Section 8: IV, B, 3, b) (Applicable 6 months after contract initiated)					
F. QUARTERLY PROGRESS NOTES (Must be a summary of monthly notes)					
1. Quarterly Progress notes reflect use of naturally occurring and community-based supports. (Section 5: V, A, 9) (8, IV, B, 3, h)					

NUMBER OF DEFICIENCIES NOTED: _____

* Applicable when training completed for personal outcomes and support strategies.

* NA = NOT APPLICABLE

REQUIREMENT	RESPONSE			COMMENTS	CORRECTIVE ACTION
F. QUARTERLY PROGRESS NOTES (Must be a summary of monthly notes) (CONT.)	Y	N	NA*		
2. Quarterly Progress notes document attempts of contact. (Section 5: V, A, 8)					
3. Quarterly Progress notes support CPOC. (Section 5: V, A 4, 5)					
* 4. Quarterly Progress notes support personal outcomes. (Section 5, V, A, 9)					
* 5. Quarterly Progress notes document status of goals/desired outcomes. (Section 5, V, A, 9)					
* 6. Quarterly Progress notes document opportunities and obstacles related to support strategies and/or personal outcomes. (Section 5: V, 9, d)					
* 7. Quarterly Progress notes document action plan which addresses obstacles and opportunities related to support strategies and/or personal outcomes. (Section 5: V, 9, f)					
G . SUPPORT STRATEGIES (*WHEN APPLICABLE)					
1. Are formal and informal services arranged? (Section 5, III, 2, a)					
2. Participation of recipient/guardian in developing formal/informal support strategies is documented. (Section 5: III, B, 5)					
3. Are there activities that provide recipient with new/different experiences of choice, as desired and appropriate? (Section 5: III, 2)					
* 4. Support strategies relate directly to personal outcomes. (Section 5: III, 2)					

NUMBER OF DEFICIENCIES NOTED: _____

* Applicable when training completed for personal outcomes and support strategies.

* NA = NOT APPLICABLE

REQUIREMENT	RESPONSE			COMMENTS	CORRECTIVE ACTION
G . SUPPORT STRATEGIES (CONT.)	Y	N	NA*		
* 5. Support strategies include cost-effective use of formal services if need cannot be met through informal/natural supports (Section 5: III)					
H. FOLLOW-UP					
1. Recipient has been contacted within 10 working days following receipt of the approved initial CPOC. (Section 5: V, A, 1)					
2. Quarterly home visits have been completed. (Section 5: V, 2, b)					
3. Quarterly monitoring by the case manager is documented. (Section 5: V, 2)					
I. RECORD REVIEW					
1. All record entries and forms are dated and signed. (Section 8 IV, B)					
2. Document if Error Correction procedure is followed. (Section 8: IV A)					
3. At least 6 months documentation of progress notes are present. (Section 8, IV, B, 1, h)					
4. Confidentiality requirements are met. (Section 8, I, C) (Access sheet) (Client rights) (signed releases)					
5. Case Manager has verified the billing of service provider and analyzed the usage of service. (Waiver Service Manual 22-7.2)(Section 5, V, A, 2)					

NUMBER OF DEFICIENCIES NOTED: _____

* Applicable when training completed for personal outcomes and support strategies.

* NA = NOT APPLICABLE

REQUIREMENT	RESPONSE			COMMENTS	CORRECTIVE ACTION
J. TRANSITION/CLOSURE	Y	N	NA*		
1. Closure criteria was met per case management manual. (Section 5: VIII)					
K. OUTCOMES					
* 1. A person centered plan has been developed for this recipient.					
* 2. Personal outcomes indicated in CPOC are present, ie., achieved or maintained per desire of recipient/guardian.					

TOTAL NUMBER OF DEFICIENCIES NOTED: _____

*** Applicable when training completed for personal outcomes and support strategies.**

* NA = NOT APPLICABLE

L. INTERVIEWS							
1. Name/Relationship							

COMMENTS:

REVIEWER SIGNATURE:	TITLE:	DATE:
REVIEWER SIGNATURE:	TITLE:	DATE:

CORRECTIVE ACTION SUBMITTED BY: _____ _____
Signature Date

* NA = NOT APPLICABLE

REPLACEMENT PA REQUEST FORM

Date of Request: ___ / ___ /_____

Agency Name: _____

Agency Region: _____

Medicaid Provider Number: _____

Agency Telephone: _____

Agency Fax: _____

Client Name: _____
(Please Print)

Client SSN Number: _____ - ____ - _____

Existing PA Number: _____

New Medicaid Number: _____

_____ _____
Signature of Requesting Party Date

Please mail request to:

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

SRI DOES NOT VERIFY MEDICAID ELIGIBILITY NOR DETERMINE IF THE CONSUMER IS IN THE TARGET POPULATION. IT IS THE RESPONSIBILITY OF THE PROVIDER TO ENSURE ELIGIBILITY.

Case No._____
Date:_____
No. of Deficiencies_____

SERVICE PROVIDER MONITORING REPORT FORM
COMPLIANCE REQUIREMENT CHECKLIST
_____QUARTER _____YEAR

RECIPIENT NUMBER: REGION:	COMPANY NAME: CASE MANAGER: PHONE NUMBER:
NAME AND ADDRESS OF FACILITIES:	FACILITY DIRECTOR: PROGRAM DIRECTOR: PHONE NUMBER:
FACILITY MEDICAID PROVIDER NUMBER: PROVIDER TYPE: DOES THE FACILITY HAVE A "PROVISIONAL LICENSE"? YES_____ NO_____	IS DSS SURVEY AVAILABLE FOR REVIEW? YES _____ NO _____ DATE OF SURVEY:
DOES THE FACILITY HAVE A CURRENT LICENSE ISSUED BY DSS? YES _____ NO _____ DATE OF EXPIRATION: LICENSE NUMBER: IS ADDRESS COMPLETE? YES _____ NO _____	WERE DEFICIENCIES PRESENT? YES_____ NO _____ IF DEFICIENCIES WERE NOTED, HAVE THEY BEEN CORRECTED? YES _____ NO _____ DATE OF FOLLOW-UP SURVEY:

REQUIREMENTS	RESPONSE			DEFICIENCIES (Add Comments on Page 5, include reference #)	CORRECTIVE ACTION
	YES	NO	N/A		
A. CPOC COMPLIANCE					
1. THE AGENCY DOES HAVE A CURRENT SERVICE PLAN.					
2. THE PLAN DESCRIBES THE SERVICES TO BE DELIVERED.					
3. THE PLAN REFLECTS PERSONNEL GOALS.					
4 . THE AGENCY SERVICE PLAN IS IN COMPLIANCE WITH THE CPOC.					
5. * THE SERVICE PLAN DESCRIBES STRATEGIES FOR COMPLETING THE DESIGNATED OUTCOMES. (* WHEN APPLICABLE)					

NUMBER OF DEFICIENCIES NOTED: _____

REQUIREMENTS	RESPONSE			DEFICIENCIES	CORRECTIVE ACTION
B. COMPLAINT PROCEDURE	**YES**	**NO**	**N/A**		
1. THE AGENCY HAS AN ADEQUATE POLICY AND PROCEDURE TO ADDRESS COMPLAINTS.					
2. THE AGENCY MAINTAINS DOCUMENTATION OF COMPLAINTS.					
3. THE AGENCY MAINTAINS DOCUMENTATION OF COMPLAINT RESOLUTIONS.					
4. THE AGENCY HAS A POLICY & PROCEDURE FOR REPORTING INCIDENTS.					
5. THE AGENCY IMPLEMENTS A PROCEDURE FOR RECEIVING AND RESOLVING COMPLAINTS.					
6. THE AGENCY MAINTAINS DOCUMENTATION FOR INCIDENT REPORTS/FINDINGS.					
7. COPY OF THE INCIDENT REPORT AND ITS FINDINGS WAS SENT TO CASE MANAGEMENT.					
C. STAFFING COMPLIANCE					
1. THE AGENCY COMPLIES WITH STAFFING REQUIREMENTS: A. REVIEW PERSONNEL ROSTER 1. Drivers license 2. Criminal background check 3. Training 4. Supervision. 5. Annual Evaluation. B. REVIEW TIME SHEETS C. IS ANYONE IN THE RECIPIENT'S FAMILY, LIVING IN THE HOUSEHOLD, PROVIDING PAID SERVICES TO THEM?					
2. THE AGENCY DOCUMENTS COMMUNICATION BETWEEN THE SERVICE PROVIDER AGENCY AND THE CASE MANAGER. PHONE____ FAX_____ LETTER_____					

NUMBER OF DEFICIENCIES NOTED: _____

NUMBER OF DEFICIENCIES NOTED: _____

REQUIREMENTS	RESPONSE			DEFICIENCIES	CORRECTIVE ACTION
D. BILLING COMPLIANCE	YES	NO	N/A		
1. THE AGENCY MAINTAINS THREE MONTHS OF TIME SHEETS FOR REVIEW.					
2. THE AGENCY MAINTAINS THREE MONTHS OF REMITTANCE ADVICE FOR REVIEW.					
3. THE TIME SHEETS MATCH THE CPOC.					
4. THE PROGRESS NOTES MATCH THE CPOC.					
5. THE BILLING DOCUMENTS MATCH TIME SHEETS.					
6. THE BILLING DOCUMENTS MATCH PROGRESS NOTES.					
7. THE TIME SHEET IS SIGNED BY STAFF AND SUPERVISOR.					
8. THE PROVIDER RETAINS FOR AUDIT, COPIES OF TIME SHEETS.					
9. THE PROVIDER RETAINS FOR AUDIT, COPIES OF PROGRESS NOTES (RETAIN AT LEAST 6 MONTHS PROGRESS NOTES).					
10. MR/DD 14'S ARE CURRENT.					
11. MR/DD 14'S MATCH CURRENT CPOC.					
12. BILLING MATCHES HOURS AUTHORIZED APPROVED CPOC.					
13. REIMBURSEMENT/JUSTIFICATION OF BILLING IS REQUIRED. YES_____ NO _____					

NUMBER OF DEFICIENCIES NOTED: _____

NUMBER OF DEFICIENCIES NOTED: _____

REQUIREMENTS	RESPONSE			DEFICIENCIES	CORRECTIVE ACTION
E. RECORD REVIEW	**YES**	**NO**	**N/A**		
1. EACH ENTRY AND FORMS DATED, SIGNED, AND LABELED WITH RECIPIENT'S NAME.					
2. DOCUMENT IF ERROR CORRECTION PROCEDURE IS FOLLOWED.					
3. NOTIFICATION OF CLIENT'S RIGHTS IS MAINTAINED IN RECIPIENT'S RECORD.					
F. HEALTH & SAFETY					
1. DOES THE RECIPIENT/FAMILY REQUIRE A SPECIAL NEEDS SHELTER?					
2. DOES THE AGENCY MAINTAIN A CURRENT INDIVIDUALIZED EMERGENCY PREPAREDNESS PLAN FOR THE RECIPIENT?					
G. CONFIDENTIALITY					
1. ACCESS TO RECORDS IS SIGNED AND DATED BY EACH REVIEWER.					
2. RECIPIENT HAS BEEN NOTIFIED OF THE AGENCY'S CONFIDENTIALITY POLICY.					

TOTAL NUMBER OF DEFICIENCIES NOTED: _____

NUMBER OF DEFICIENCIES NOTED: _____

PERSON (S) INTERVIEWED AND THEIR TITLE:

COMMENTS:

REVIEWER SIGNATURE:	**TITLE:**	**DATE:**
REVIEWER SIGNATURE:	**TITLE:**	**DATE:**

CORRECTIVE ACTION SUBMITTED BY: _____ _____

Signature **Date**

Revised 09/14/2000

APPENDIX C

ADDITIONAL INFORMATION

BCSS REQUIREMENTS FOR PROVIDER BROCHURES
CMIS SERVICE LOG
COMPLEXITY SCALE - MR/DD WAIVER
COMPONENTS OF 24 HOUR COVERAGE
COMPONENTS OF A QUALITY IMPROVEMENT PLAN
DOCUMENTATION SCHEDULE
OVERVIEW OF THE ENTRY PROCESS:
- ADULT DAY HEALTH
- CHILDREN'S CHOICE
- ELDERLY & DISABLED ADULT
- EPSDT TARGETED POPULATION
- HIV/AIDS
- MENTALLY RETARDED/DEVELOPMENTALLY DISABLED
- NURSE HOME VISITS FOR FIRST TIME MOTHERS
- PERSONAL CARE ATTENDANT(PCA)

HELP LINE
KARNOFSKY PERFORMANCE SCALE (REFERENCED IN HIV SECTION)
MONITORING OF SERVICE PROVIDERS CHECKLIST
QUARTERLY REPORTING FORM FOR CASE MANAGEMENT
RIGHTS AND RESPONSIBILITIES FORM

BCSS REQUIREMENTS FOR PROVIDER BROCHURES

Brochures must include the following:

1. The following two paragraphs must be included in the brochure. It must be the same type and the same size as the print of the remainder of the brochure. The paragraphs bust be separate and exactly as written below:

    a. "Each Medicaid recipient of targeted or waiver case management has the freedom to choose their providers. The recipient's choice of case management or waiver service(s) providers does not effect their eligibility for the waiver or case management services."

    b. "Recipients of Medicaid Case Management Services may report any problems with their case management services or waiver services to the Bureau of Community Supports and Services Help line Manager at 1-800-660-0488."

2. The agencies physical address and mailing address, if different.

3. The 24 hour toll-free number: On the brochure make sure to include the words Toll-free in front of the number (i.e., Toll-Free: 1-800 and the number).

4. Should include the Agencies experience and marketing information.

5. Additional copies shall be provided upon notification from DHH.

6. **Shall not be printed until written approval is received from the Case Management Program Administrator.**

7. Must reflect the Children's Choice and EPSDT populations and must also be revised when new populations have been introduced to the BCSS waiver services program.

REVISED 07-19-01

LOUISIANA BUREAU OF HEALTH SERVICES FINANCING
CMIS SERVICE LOG

Service Log #: _ _ _ _ _ _ _

Case Number: _ _ _ _ _ **Client Name:** _____

Case Manager ID: _ _ _ _

---

1. Date: _ _/_ _/_ _ **5. Activity:** _ NOTES:

2. Begin Time: _ _ : _ _ (hh:mm) **6. Outcome Addressed:** (NA)

3. Place of Service: _ **7. Service Participants:** _ _

_ _

4. Type of Contact: _ _ _

_ _

1

---

1. Date: _ _/_ _/_ _ **5. Activity:** _ NOTES:

2. Begin Time: _ _ : _ _ (hh:mm) **6. Outcome Addressed:** NA

3. Place of Service: _ **7. Service Participants:** _ _

_ _

4. Type of Contact: _ _ _

_ _

2

---

1. Date: _ _/_ _/_ _ **5. Activity:** _ NOTES:

2. Begin Time: _ _ : _ _ (hh:mm) **6. Outcome Addressed:** NA

3. Place of Service: _ **7. Service Participants:** _ _

_ _

4. Type of Contact: _ _ _

_ _

3

Case Manager Signature Date

CMIS SERVICE LOG CODES

MILITARY TIME CONVERSION TABLE

STANDARD	MILITARY	STANDARD	MILITARY
1:00 A.M.	1:00	1:00 P.M.	13:00
2:00 A.M.	2:00	2:00 P.M.	14:00
3:00 A.M.	3:00	3:00 P.M.	15:00
4:00 A.M.	4:00	4:00 P.M.	16:00
5:00 A.M.	5:00	5:00 P.M.	17:00
6:00 A.M.	6:00	6:00 P.M.	18:00
7:00 A.M.	7:00	7:00 P.M.	19:00
8:00 A.M.	8:00	8:00 P.M.	20:00
9:00 A.M.	9:00	9:00 P.M.	21:00
10:00 A.M.	10:00	10:00 P.M.	22:00
11:00 A.M.	11:00	11:00 P.M.	23:00
12:00 Noon	12:00	12:00 Midnight	24:00

CASE MANAGEMENT SERVICE LOG CODES

3. PLACE OF SERVICES

01. Supervised Apartment or Substitute Family
02. Home
03. Group or Community Home for OCDD
04. Large Facility (16+) for OCDD
05. Public Hospital (medical unit)
06. Public Hospital (psychiatric unit)
07. Private Hospital (medical unit)
08. Private Hospital (psychiatric unit)
09. Day Program
10. Mental Health Clinic
11. Public Mental Hospital
12. School
13. Case Management Agency
14. Jail or Correctional Facility
15. Regular day care or nursery school
16. OT, PT, Speech Therapist's Office
17. Medical Clinic
18. Early Intervention Provider
19. Waiver Service Provider's Place of Business
20. Public Health Unit
99. Other Community Location

4. TYPE OF CONTACT

1. In person
2. Telephone
3. Written

5. SERVICE ACTIVITY

01. Intake
02. Assessment
03. Service Planning
04. Linkage
05. Observation of Services
06. Reassessment
07. Transition/Closure
08. Enter ICF/MR Residential
09. Exit ICF/MR Residential
10. Advocacy
11. Monitoring of Service Provider Billing Records
12. Follow-up to Implementation of CPOC/IFSP
(Activity codes 20-25 are for VACP only)
20. Medical Consultation
21. Health Management
22. Medical Crisis Management
23. Medical Crisis Training & Tech. Assistance - School
24. Medical Crisis Training & Tech. Assistance - Community
25. Intense Informing for Complex Health Needs
(Activity code 30 is for First Time Mothers only)
30. Teaching/Activity covering Personal Health, etc.

7. SERVICE PARTICIPANTS

01. Client
02. Parent or Legal Guardian
03. Other Family Member or Essential Other
04. Residential Service Provider
05. Day Service Provider
06. Waiver Service Provider
07. Education
08. Health
09. Supportive Services
99. Other

LOUISIANA BUREAU OF HEALTH SERVICES FINANCING
CMIS SERVICE LOG

Service Log #: _ _ _ _ _ _ _

Case Number: _ _ _ _ _ **Client Name:** _____

Case Manager ID: _ _ _ _

---

1. Date: _ _/_ _/_ _

2. Begin Time: _ _ : _ _ (hh:mm)

3. Place of Service: _

4. Type of Contact: _

5. Activity: _

6. Outcome Addressed: (NA)

7. Service Participants: _ _
_ _
_ _
_ _

Notes:

1

Case Manager Signature Date

---

1. Date: _ _/_ _/_ _

2. Begin Time: _ _ : _ _ (hh:mm)

3. Place of Service: _

4. Type of Contact: _

5. Activity: _

6. Outcome Addressed: (NA)

7. Service Participants: _ _
_ _
_ _
_ _

Notes:

2

Case Manager Signature Date

CMIS SERVICE LOG CODES

MILITARY TIME CONVERSION TABLE

STANDARD	MILITARY	STANDARD	MILITARY
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7:00 A.M.	7:00	7:00 P.M.	19:00
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CASE MANAGEMENT SERVICE LOG CODES

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04. Large Facility (16+) for OCDD
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06. Public Hospital (psychiatric unit)
07. Private Hospital (medical unit)
08. Private Hospital (psychiatric unit)
09. Day Program
10. Mental Health Clinic
11. Public Mental Hospital
12. School
13. Case Management Agency
14. Jail or Correctional Facility
15. Regular day care or nursery school
16. OT, PT, Speech Therapist's Office
17. Medical Clinic
18. Early Intervention Provider
19. Waiver Service Provider's Place of Business
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99. Other Community Location

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06. Waiver Service Provider
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08. Health
09. Supportive Services
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LOUISIANA BUREAU OF HEALTH SERVICES FINANCING
CMIS SERVICE LOG

Service Log #: _ _ _ _ _ _ _ _

Case Number: _ _ _ _ _ **Client Name:** _____

Case Manager ID: _ _ _ _

---

1. Date: _ _/_ _/_ _

2. Begin Time: _ _ : _ _ (hh:mm)

3. Place of Service: _

4. Type of Contact: _

5. Activity: _

6. Outcome Addressed: (NA)

7. Service Participants: _ _
_ _
_ _
_ _

Notes:

_____
Case Manager Signature Date

CMIS SERVICE LOG CODES

MILITARY TIME CONVERSION TABLE

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5:00 A.M.	5:00	5:00 P.M.	17:00
6:00 A.M.	6:00	6:00 P.M.	18:00
7:00 A.M.	7:00	7:00 P.M.	19:00
8:00 A.M.	8:00	8:00 P.M.	20:00
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CASE MANAGEMENT SERVICE LOG CODES

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11. Public Mental Hospital
12. School
13. Case Management Agency
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05. Day Service Provider
06. Waiver Service Provider
07. Education
08. Health
09. Supportive Services
99. Other

COMPLEXITY SCALE FOR MR/DD WAIVER SERVICES

Client Name:_____

1. Health Status: ___
   - 1 = No major problem
   - 2 = Mild
   - 3 = Moderate
   - 4 = Severe

2. Mobility: ___
   - 1 = Unimpaired
   - 2 = Mild
   - 3 = Moderate
   - 4 = Mobile/Non-Ambulatory
   - 5 = Non-Ambulatory

3. Coordination: ___
   - 1 = Unimpaired
   - 2 = Reduced
   - 3 = Disabling

4. Hearing Loss: ___
   - 1 = None/Mild
   - 2 = Moderate/Moderately Severe
   - 3 = Severe/Profound

5. Visual Handicap: ___
   - 1 = None
   - 2 = Mild
   - 3 = Moderate
   - 4 = Severe

6. Speech Handicap: ___
   - 1 = None
   - 2 = Mild
   - 3 = Moderate
   - 4 = Severe

7. Behavior Management: ___
   - 1 = None
   - 2 = Mild
   - 4 = Moderate
   - 6 = Severe

8. Prosthetics: (enter a ☑ for each item) Not used to compute Total Score

Hearing Aid	___	Orthopedic Appliances	___
Dental Prosthetics	___	Special Positioning Equipment	___
Corrective Lenses	___	Adaptive Eating Device	___
Wheelchair	___	Augmented Communication Device	___
Walker/Cane	___	Other_____	
Orthopedic Shoes	___	(specify)	

BCSS
12-5-2000

9. Intelligence Level Per Psychological: ___

0 = Not Retarded	3 = Severe (IQ 34-20)
1 = Mild (IQ 70-50)	4 = Profound (IQ < 20)
2 = Moderate (IQ 49-35)	5 = Diagnosis Not Determined (0-3 only)

10. Adaptive Behavior Level: ___

0 = Normal Range	3 = Severe
1 = Mild	4 = Profound
2 = Moderate	5 = Diagnosis Not Determined (0-3 only)

SCORE_____

CASE MANAGER_____

DATE_____

CLIENT LEVEL OF SUPPORT: INSTRUCTIONS

PREPARATION - This assessment of a consumer's needs for higher levels of support for personal care services, respite care, day habilitation, pre-vocational habilitation and supported employment services is completed by the case manager using this form and supportive documentation. It is to be completed as part of all initial Comprehensive Plans of Care (CPOC). For recipients of high need personal care or respite and for any recipient receiving day habilitation, pre-vocational habilitation or supported employment this form is to be completed and submitted for any subsequent CPOC revisions or updates. It is to be signed by the case manager, and signed by the BCSS staff member who reviews it.

TOTAL SCORE - (At bottom of page two) Enter the sum of all scores for the following categories, except PROSTHETICS- No points are added to the score for checks in this category.

HEALTH STATUS - Enter the number indicating the category which describes the client's health status based on the following definitions.

1 - No major problems. The individual's health status does not meet the following definitions of mild, moderate or severe.
2 - Mild. The individual has stable chronic conditions (e.g. history of seizures which are now controlled, weight control problems) which do not adversely affect daily living.
3 - Moderate. The individual has chronic health problems (e.g. uncontrolled seizures, heart ailment) which requires professional intervention (more than just medication administration), but less than daily.
4 - Severe. The individual's health status is unstable or there are serious multiple health problems which may be life-threatening, requiring professional intervention on a daily basis.

MOBILITY - Enter the number indicating the category which describes the client's mobility status based on the following definitions.

1 - Unimpaired. The individual is able to walk, run and climb stairs with ease.
2 - Mild. The individual is able to walk, but perhaps at a slow rate: may have some difficulty in running smoothly, or in climbing stairs, does not alternate feet on the steps.
3 - Moderate. The individual is able to walk, but may sometimes require the assistance of another person; running is difficult or results in frequent falls; or assistance is required in climbing stairs.
4 - Mobile-non-ambulatory. The individual is unable to walk unassisted, but is able to move from place to place (e.g. across the room) with the use of a physical device such as a wheelchair or walker.
5 - Non-ambulatory. The individual is unable to purposefully move from place to place even with the use of a physical device.

BCSS
12-5-2000

COORDINATION - Enter the number indicating the category which describes the client's level of coordination based on the following definitions:

1 - Unimpaired. The individual is able to balance body well and has good control of all limbs.
2 - Reduced. The individual has some problems with body balance or fine motor control of limbs.
3 - Disabling. The individual has severe problems with body balance (e.g. cannot maintain head or trunk control) or with both fine and gross motor control of limbs.

HEARING LOSS - Enter the number indicating the category which best describes the client's level of hearing loss. The level of loss should be determined without a hearing aid, if the client wears one. The rating scale being used is based on the 1969 ANSI reference:

1 - Normal to Mild. Up to a 40 dB loss. Clients at this level may have normal hearing or have difficulty hearing faint or distant speech.
2 - Moderate to Moderately Severe. 41 - 70 dB loss. Clients at this level may hear conversational speech at a distance of 3 to 5 ft., or conversation must be loud to be heard.
3 - Severe to Profound. 71 - 91+ dB loss. Clients at the Severe level may hear a loud voice about 1 foot from the ear, may identify environmental noises, and may be able to distinguish vowels but not consonants. Clients at the Profound level may hear loud sounds, but do not rely on hearing as a primary channel for communication.

VISUAL HANDICAP - Enter the number indicating the category which best describes the client's level of visual impairment. The level of loss should be determined without corrective lenses, if the client wears them. If either standard assessment techniques or some of the new techniques for nonverbal clients based on discrimination ability do not produce valid results, the physician should use his or her own judgement in determining which category applies to a client. The following categories apply to the degree of visual acuity in the better eye. If there is a large discrepancy between distance and near vision, choose the category which best reflects the client's overall visual functioning.

1 - None. 20/20 or better.
2 - Mild. Less than 20/20, but better than 20/70.
3 - Moderate. 20/70 or less, but better than 20/200.
4 - Severe. 20/200 or less.

SPEECH HANDICAP - Enter the number indicating the category which describes the client's level of articulation and language usage. If articulation and language usage are at different levels, enter the number associated with the more severe impairment. Disregard signing ability.

1 - None. The individual has no noticeable articulation problems and/or uses complex sentences.
2 - Mild. The individual exhibits occasional articulation problems and/or uses only simple sentences.
3 - Moderate. The individual's articulation problems are noticeable in most speech and/or uses only phrases.
4 - Severe. The individual's speech is largely unintelligible by strangers, and/or meaningful speech is absent or limited to a few simple words.

BEHAVIOR MANAGEMENT - Enter the number indicating the category which describes the client's behavior management problems based on the following definitions:

1 - None. The individual does not exhibit behaviors which require either informal or programmatic intervention.
2 - Mild. The individual exhibits behaviors that are not acceptable in normal situations, but these do not disrupt the client's program to a large degree or interfere with the performance of daily living activities. These behaviors can often be ignored or dealt with through innocuous interventions such as redirection. Examples: self-stimulatory behaviors, noncompliance, withdrawal, attention-seeking.
4 - Moderate - The individual exhibits behaviors that are disruptive, interfere with the carrying out of daily living activities and cannot be ignored or reduced through the use of redirection. These behaviors require direct intervention, usually in the form of a deceleration technique, in addition to procedures for teaching a more functional behavior. Examples: rage reactions, property destruction, aggression, and mild behavior problems displayed at high frequencies or intensities.
6 - Severe - The individual exhibits behaviors that cause a major disruption and threatens the health and safety of the client, peers or staff if allowed to continue. These behaviors are often not amenable to non-intrusive techniques and require more intense intervention to manage the situation. Examples: violent aggression, major destruction of property, self-injurious behavior, and moderate behavior problems displayed at high frequencies or intensities.

PROSTHETICS - Put a check by each item that is currently required by the client on a daily basis. If an appropriate category is not listed, enter the relevant description in the item labeled Other.

ABL (Adaptive Behavior Level) - Enter the appropriate number indicating the client's current adaptive behavior level.

0 - No impairment 1- Mild 2- Moderate 3 - Severe 4 - Profound

INTELLIGENCE LEVEL PER PSYCHOLOGICAL - Enter the number indicating the category which best represents the client's level of intellectual impairment according to the DSM - III criteria. The IQ ranges listed below are simple rough guides since these vary by test instrument. SQs, DQs or similar scores may be considered generally comparable to IQs. The unspecified category should be used only in rare instances.

1- Mild (IQ 50-70) 2 - Moderate (IQ 35-49) 3 - Severe (IQ 20-34) 4 - Profound (IQ below 20)

Components of 24 Hour Coverage

1. 24 hour Toll free number

2. Must be manned by a person so that the recipient only has to make one call

3. Who will answer the toll-free phone during business hours and after hours? (e.g., will it be answered in the office during 8-5 and by an answering service after hours and weekend?)

   NOTE: An answering service does not mean voice mail or an answering machine.

4. Is there a procedure for screening the calls or will all calls be answered by a case manager?

5. What is the procedure to get in touch with a case manager to call the recipient? And what is the time frame for them to get in touch with the case manager?

6. What is the procedure/time frame for the case manager to respond?

7. How will you monitor the answering service and staff response? What is the wait time for the recipient holding? Is there a call waiting feature to alleviate busy signals?

8. Do you share the number with another one of your agencies that also have a contract?

All plans shall be signed by the Contract Administrator (the name of the Board Resolution)

REVISED 07-19-01

COMPONENTS OF A QUALITY IMPROVEMENT PLAN

I. Organization Vision
II. Organization Mission
III. Organizational Chart
IV. Goals of the Quality Improvement Program
V. Objectives of the Quality Improvement Program
VI. Role of the Governing Body in Relation to the Quality Improvement Program
VII. Composition of the Quality Improvement Committee/Staff
VIII. Role of the Quality Improvement Committee/Staff
IX. Scope of the Quality Improvement Program
X. Important/Critical Aspects of Care
    A. Indicators
        1) Thresholds
        2) Data Sources
        3) Data Collection Method
        4) Appropriateness of Sampling
        5) Frequency of Data Collection
XI. Monitoring and Evaluation Procedures
XII. Focused Quality of Care Studies
XIII. Complaints/Grievances Policies and Procedures
XIV. Satisfaction Surveys
XV. Recipients Rights and Responsibilities
XVI. Remedial Action Plan
XVII. Annual Evaluation of Quality Improvement Plan

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

Adult Day Health Care Waiver (ADHC) Overview of the Entry Process

Step 1
BCSS/Contractor (SRI)

- ✓ Requestor accepts waiver opportunity
- ✓ FOC is sent and completed
- ✓ Send all (if any) waiver criteria documentation to ADHC Agency with Linkage info
- ✓ Send notification/listing to BCSS RO re: linkage

Step 2
ADHC Agency

- ✓ Receives linkage info with any assessment info that validates they have met the waiver criteria
- ✓ Contacts requestor within three calendar days of notification of linkage
- ✓ Obtain any missing documentation identifying disability (if applicable - Medical History w/diagnosis or SSI approval)
- ✓ Assists requestor with obtaining a 90-L that states disability; if disability met then proceed. If disability not met, contact BCSS R.O.
- ✓ Complete MDS-HC
- ✓ Sets CPOC appointment with requestor & Authorized Representative (if applicable)

Step 3
ADHC Agency

- ✓ CPOC finalized & signed by requestor, Authorized Representative & others that attend the planning meeting
- ✓ At CPOC meeting, the following forms should be explained: Rights & Responsibilities, Waiver Fact Sheet, Medicaid Services Chart, and Help Line
- ✓ Submits a complete CPOC packet to BCSS R.O. within 35 calendar days of linkage
- ✓ Financial application sent to BHSF Parish Office

Step 4
BCSS Regional Office

- ✓ Receives CPOC Packet (return if incomplete)
- ✓ Review MDS-HC
- ✓ Validates that the following have been given, signed, and explained:
  FOC, Rights & Responsibilities Form, Authorized Representative - if applicable, Waiver Fact Sheet, Medicaid Services, and Help Line
- ✓ Issues approved 142 to BHSF Parish Office only

Step 5
BHSF Medicaid Parish Office

- ✓ Financial Eligibility determined
- ✓ 18W issued for approval or disapproval

Step 6
BCSS Regional Office

- ✓ After receipt of the 18W, the 51NH is completed with the admission date being the same date as the date on the18W, and the vendor payment begin date is the admit date on the 18W
- ✓ The CPOC begin date is the date on the 18W and the CPOC end date is the day before the begin date, a year later
- ✓ Copies of the approved 51NH & CPOC are sent to the ADHC (142 sent to Provider & recipient)
- ✓ Copies of the 51-NH, CPOC demographic, budget, & approval pages are sent to SRI for linkage purposes

Step 7
ADHC Agency

- ✓ Sends a copy of the approved CPOC to the recipient/Authorized Representative
- ✓ Implements the ADHC Services in the CPOC if not previously done

Step 8
ADHC Agency

- ✓ Annual CPOC completed and submitted to BCSS Regional Office no less than 35 calendar days prior to expiration
- ✓ Send 148 to BHSF, BCSS R.O., and SRI on changes regarding address, hospitalizations, discharges, transfers, etc.

Children's Choice (CC) Waiver Overview of the Entry Process

Step 1
BCSS/Contractor (SRI)
- ✓ Requestor accepts Children's Choice
- ✓ All yes responses sent to ACS

Step 2
Affiliated Computer Systems (ACS)
- ✓ If no SOE, then ask legal guardian for a current 1508 **or** if SOE is questionable provide a current SOE of other psychological data
- ✓ Contact legal guardian to see if already SSI eligible and to complete a mini-social
- ✓ If requestor appears eligible, a 90-L is requested
- ✓ Inform of Kidmed & LaChip (if applicable)

Step 3
BCSS/Contractor (SRI)
- ✓ If MR/DD criteria not met, BCSS notifies requestor by letter
- ✓ If MR/DD criteria met, a Case Management FOC is sent to requestor
- ✓ When FOC is received, linkage is made to appropriate Case Management Agency
- ✓ Eligibility documents mailed to Case Management. Agency
- ✓ Requestor & BCSS R.O. notified of linkage

Step 4
Case Management Agency
- ✓ Receives FOC & linkage & eligibility documents
- ✓ Contacts requestor within three calendar days of notification of linkage
- ✓ Offers FOC of enrolled direct service provider
- ✓ Sets appointment with requestor & service provider to develop CPOC

Step 5
Case Management Agency
- ✓ CPOC finalized & signed by legal guardian, provider & others that attend the planning mtg.
- ✓ Submits a complete CPOC packet to BCSS R.O. within 35 calendar days of linkage
- ✓ Waiver application sent to BHSF Parish Office

Step 6
BCSS Regional Office
- ✓ Receives CPOC Packet (returned if incomplete)
- ✓ Conducts pre-certification home visit; provides information on informed choice, completes NC Snap, completes HRST (if necessary)
- ✓ Issues notification of approval or disapproval of CPOC via 142 to BHSF Parish Office, requestor/legal guardian & Case Mgt. Agency

Step 7
BHSF Medicaid Parish Office
- ✓ Financial Eligibility determined
- ✓ 18W issued for approval or disapproval to legal guardian, Case Management Agency, & BCSS R.O.

Step 8
Case Management Agency
- ✓ Sends copy of approved CPOC to provider & recipient/legal guardian
- ✓ Sends copy of the signature **AND** services page (page 11) of the CPOC to SRI for Prior Authorization (PA) & the 142

Step 9
BCSS/Contractor (SRI)
- ✓ PA numbers for Case Mgmt. Agency & Enrolled Provider sent to each agency
- ✓ PA released to Unisys after data is entered into system and submitted to SRI

Step 10
Enrolled Direct Service Provider Agency
- ✓ Implements the CPOC
- ✓ Meets with recipient/guardian to identify additional providers for services in the approved CPOC
- ✓ Submits appropriate data into Data Collection System prior to billing

Step 11
Case Management Agency
- ✓ Must have at a minimum, monthly telephone contacts with recipient and legal guardian
- ✓ A home visit must occur between the 6th & 9th month after approval of the CPOC, or more frequently at family's request
- ✓ Annual CPOC completed and submitted to BCSS R.O. no less than 35 calendar days prior to expiration

Elderly & Disabled (EDA) Waiver Overview of the Entry Process

Step 1
BCSS/Contractor (SRI)

- ✓ Requestor accepts waiver opportunity
- ✓ FOC is sent and completed
- ✓ Send all (if any) waiver criteria documentation to Case Management Agency with Linkage info
- ✓ Send notification/listing to BCSS RO re: linkage

Step 2
Case Management Agency

- ✓ Receives linkage info with any assessment info that validates they have met the waiver criteria
- ✓ Contacts requestor within three calendar days of notification of linkage
- ✓ Obtain any missing documentation identifying disability (if applicable - Medical History w/diagnosis or SSI approval)
- ✓ Assists individual with obtaining a 90-L that states disability; if disability met then proceed. If disability is not met, contact BCSS R.O.
- ✓ Complete MDS-HC
- ✓ Offers FOC of direct service provider
- ✓ Sets CPOC appointment with requestor, Authorized Representative (if applicable), & direct service provider

Step 3
Case Management Agency

- ✓ CPOC finalized & signed by requestor, provider & others that attend the planning meeting
- ✓ At CPOC meeting, the following forms should be explained: Rights & Responsibilities, Waiver Fact Sheet, Medicaid Services Chart, and Help Line
- ✓ Submits a complete CPOC packet to BCSS R.O. within 35 calendar days of linkage
- ✓ Financial application sent to BHSF Parish Office

Step 4
BCSS Regional Office

- ✓ Receives CPOC Packet (return if incomplete)
- ✓ Review MDS-HC prior to home visit
- ✓ Conducts pre-certification home visit & Provides information on informed choice
  Validates that they have been given/signed: Rights & Responsibilities Forms, Authorized Representative - if applicable, Waiver Fact Sheet, Medicaid Services, and Help Line have been explained
- ✓ Issues approved 142 to BHSF Parish Office only

Step 5
BHSF Medicaid Parish Office

- ✓ Financial Eligibility determined
- ✓ 18W issued for approval or disapproval

Step 6
BCSS Regional Office

- ✓ After receipt of the 18W, the 51NH is completed with the admission date the same as on the 18W and 142, but the payment begin date will be the date the 51NH is completed unless de-institutionalized, then 142 date.
- ✓ Copies of the approved 142, 51NH, & CPOC are sent to the Case Manager
- ✓ Copy of the 51-NH, CPOC demographic, budget, & approval pages, to SRI for prior authorization

Step 7
Case Management Agency

- ✓ Sends a copy of approved CPOC, 142 & 51NH to direct service provider
- ✓ Sends a copy of the approved CPOC to the recipient
- ✓ Implements the services outlined in the CPOC
- ✓ Submits appropriate data to SRI prior to billing

Step 8
BCSS/Contractor (SRI)

- ✓ PA numbers for Case Mgt. Agency & Enrolled Provider sent to each agency and BCSS R.O.
- ✓ PA released to Unisys after data is entered into system and submitted to SRI

Step 9
Enrolled Direct Service Provider Agency

- ✓ Implements the CPOC
- ✓ Submits appropriate data to SRI prior to billing

Step 10
Case Management Agency

- ✓ Must have at a minimum, quarterly face-to-face home visits (High Need requires monthly visits.)
- ✓ Annual CPOC completed and submitted to BCSS Regional Office no less than 35 calendar days prior to expiration
- ✓ Send copies of 148 to BHSF Parish Office, BCSS R.O., & SRI on changes regarding address, closure, hospital stays, etc.

EPSDT Targeted Population Flow Chart

Step 1
SRI (BCSS Contractor)

- As Medicaid eligible recipients under the age of 21 are added to the Request for Services Registry, BCSS offers the recipients EPSDT-Targeted Case Management
- If they accept, SRI sends a Case Management Freedom of Choice (FOC) Form
- SRI links the recipient with a case management contractor based on their capacity
- SRI notifies the recipient and the case management agency (sends case mgr. appropriate eligibility documentation) of the linkage

Step 2
Case Management Level

- Receives FOC from SRI
- Verify Medicaid Eligibility through REVS: 1-800-776-6323 or 225-216-7387

Step 3
Case Management Level

- Obtains other assessments such as KIDMed or Childnet if applicable, to be used in the development of the CPOC
- Person Centered Planning Team Meets
- Must include statements that recipient was notified of the following:
  Explanation all Medicaid Services
  Explanation of EPSDT Services including Personal Care Services
  KIDMED referral
- CPOC is formalized and finalized
- CPOC packet sent to BCSS Regional Office no later than 35 days of linkage
- **NOTE**: Medicaid State Plan Services may begin prior to the approval of the CPOC

Step 4
BCSS Regional Office Level

- Receives and evaluates the CPOC packet for appropriateness and completeness (incomplete packets will be returned)
- After approval forward the approval page of the CPOC to the Case Management Agency
- If disapproved, returns to agency

Step 5
Case Management Level

- Provides a copy of the approved CPOC to the recipient
- Submits a copy of the approval/signature page of the CPOC to SRI for Prior Authorization. Request for PA must be submitted within 60 calendars days of the referral - the PA will not be issued with a date that is 60 calendar days prior to receipt by SRI

Step 6
Case Management/Recipient Level

- Must link the recipient or assist them in obtaining the services necessary
- Shall have at least quarterly face-to-face visit with the recipient and more if the CPOC or family requires (Children must be at least seen during the visit)
- Follow-up with the recipient must occur quarterly to see if the recipient is receiving the services identified in the CPOC. (re-address all items in Step 3) Make sure the recipient/family feels the services are appropriate and work out any obstacles in obtaining access to the services identified in the CPOC
- Quarterly progress notes must reflect the recipient's progress toward all items in the CPOC
- All contacts must be entered into the CMIS System weekly and prior to billing

Step 7
Case Management Agency

- A complete reassessment and new CPOC must be submitted to BCSS Regional Office for approval at least 35 calendar days prior to the CPOC expiration date

Step 8
BCSS Regional Office

- Monitors the Case Management Agency to verify that services have been delivered in the time frame described in the Case Management Manual

OVERVIEW OF ENTRY PROCESS FOR HIV/AIDS

STEP 1
(BCSS/CM Agencies Level)

- Clients are referred to Case Management agencies by physicians, clinics, hospitals, nursing homes etc.
- CM Agency records demographic information on client and presents a FOC form to the client.
- Client selects a Case Management agency from the list and CM agency returns FOC to SRI.
- Once FOC is received by SRI, client will be linked to the selected Case Management agency and that agency will be notified immediately of that selection.

STEP 2
Case Management (CM) Level

•Once the CM Agency is notified they must conduct a face to face visit in the home to determine eligibility (Medicaid etc.) and level of care needed to establish the CPOC.
•CPOC is prepared and forwarded to BCSS Regional Office for approval

•NOTE: It is the responsibility of the CM Agency to verify eligibility. CM Agency <u>will not</u> be reimbursed for ineligible clients.

STEP 3
(BCSS Regional Office)

- BCSS Regional Office receives CPOC, reviews and evaluates for accuracy and completeness.
- If incomplete, it will be returned to the CM Agency with explanation.
- If deemed accurate and acceptable, CM Agency will be notified and services will be certified for payment.

STEP 4
(CM Level)

- Services will be rendered as prescribed in the CPOC and documented in progress notes
- Services will be entered into the SRI CMIS system so the CM Agencies may be reimbursed.

STEP 5
(CLOSURE - CM/SRI Level)

- If Provider loses contact with client, client moves or expires, Provider completes a form to close case and forwards form to SRI.
- SRI notifies BCSS of Case Closure.

Mentally Retarded/Developmentally Disabled (MR/DD) Waiver
Overview of the Entry Process

Step 1
SRI
- ✓ Requestor accepts MR/DD Waiver
- ✓ All yes responses sent to ACS

Step 2
Affiliated Computer Systems (ACS)
- ✓ If there is not an SOE, then ask the requestor for a current 1508 or if SOE is questionable provide a current SOE of other psychological data Contact requestor/family to see if they are already SSI eligible and to complete a mini-social
- ✓ If it appears they are eligible a 90-L is requested
- ✓ Inform of Kidmed & LaChip (if applicable)

Step 3
BCSS/Contractor (SRI)
- ✓ If MR/DD criteria is not met, BCSS notifies individual by letter
- ✓ If MR/DD criteria is met, a Case Management FOC is sent to the requestor
- ✓ When FOC is received, linkage is made to the appropriate Case Management Agency
- ✓ Eligibility documents mailed to the Case Management Agency
- ✓ Requestor & BCSS R.O. is notified of linkage

Step 4
Case Management Agency
- ✓ Receives FOC, Linkage & eligibility documents
- ✓ Contacts requestor within three calendar days of notification of linkage
- ✓ Offers FOC of enrolled direct service provider
- ✓ Sets appointment with requestor & service provider to develop CPOC

Step 5
Case Management Agency
- ✓ CPOC finalized & signed by legal guardian, provider & others that attend the planning meeting
- ✓ Submits a complete CPOC packet to BCSS R.O. within 35 calendar days of linkage
- ✓ Waiver application sent to BHSF Parish Office

Step 6
BCSS Regional Office
- ✓ Receives CPOC Packet (returned if incomplete)
- ✓ Conducts pre-certification home visit; provides information on informed choice, completes NC Snap, completes HRST (if necessary)
- ✓ Issues notification of approval or disapproval of CPOC via 142 to Medicaid Parish Office, requestor and Case Management Agency

Step 7
BHSF Medicaid Parish Office
- ✓ Financial Eligibility determined
- ✓ 18W issued for approval or disapproval to requestor, Case Management Agency, & BCSS R.O.

Step 8
Case Management Agency
- ✓ Send copy of approved CPOC to provider and recipient and/or legal guardian
- ✓ Sends copy of the signature **AND** services page (page 11) of the CPOC to SRI for Prior Authorization (PA) & the 142

Step 9
BCSS/Contractor (SRI)
- ✓ PA numbers for Case Management Agency & Enrolled Provider sent to each agency
- ✓ PA released to Unisys after data is entered into system and submitted to SRI

Step 10
Case Management Agency
- ✓ Implements the CPOC
- ✓ Must have at a minimum, quarterly face-to-face home contacts with recipient or more frequently at family's request
- ✓ Annual CPOC completed and submitted to BCSS Regional Office no less than 35 calendar days prior to expiration

OVERVIEW OF ENTRY PROCESS FOR NURSE HOME VISITS PROGRAM

STEP 1
(At OPH Level)

- First Time Pregnant Mother referred to OPH by OPH Clinics, private providers, community/school agencies or by self referral.
- Nurse Home Visitor speaks to recipient to determine is she is a first time mother, Medicaid Eligible and less than 28 weeks gestation.
- Recipient is assigned to a Nurse Home Visitor or placed on waiting list if nurse caseload is full.
- Freedom of Choice form is reviewed and signed by recipient on first home visit with Nurse Home Visitor.

STEP 2
(OPH LEVEL)

- Freedom of Choice form and Recipient Data Form sent to SRI. All data regarding recipient entered into CMIS Program and sent electronically to SRI.

STEP 3
(At OPH/CM Level)

Ongoing assessment conducted by Nurse Home Visitor focusing on the <u>six Domains of Functioning</u>

- <u>Personal health, Environmental health, Life course development, Maternal role , Family and Friend support, Health and Human Services.</u>
- Home visits must be once a week during the first month of enrollment.
- Every other week through the delivery of the child.
- All services entered into CMIS.

STEP 4
(At SRI/OPH Level)

- SRI issues PA numbers once visit criteria is met. PA numbers sent to OPH Nurse Home Visitor Supervisor and entered into CMIS.
- Billing files sent to UNISYS by OPH

STEP 5
(At OPH-BCSS Level)

- Focus is shifted to the child once born and after a determination of whether or not the child is eligible for Infant and Toddlers is made, a CPOC must be completed within 6 weeks of birth.
- CPOC must be sent to BCSS Regional Office for approval.
- Regional BCSS Office determine approval of CPOC. If the child is not eligible, referral is made for I/T program.

STEP 6
(At BCSS - OPH/CM Level)

- BCSS sends approval page of CPOC to OPH Nurse Home Visitor Supervisor.
- Nurse Home Visitor sends approval page and recipient data form of baby to SRI.

STEP 7

- SRI issues PA numbers once visit criteria is met and approved CPOC is received. PA numbers sent to OPH Nurse Home Visitor Supervisor and entered into CMIS.
- Billing files sent to UNISYS.

OVERVIEW OF ENTRY PROCESS FOR NURSE HOME VISITS PROGRAM

STEP 8
(At OPH/CM - BCSS level)

- Nurse Home Visitor completes annual CPOC 35-90 days before child's first birthday and send to BCSS Regional office for approval.
- If acceptable, issues notification of approval of CPOC via the approval page.
- Refer to Infant and Toddlers criteria. If eligible for I/T then Nurse Home Visit case must be closed.
- Confirmation of closure should be sent to BCSS Regional Office

STEP 9
(At BCSS/CM Level)

- Approved CPOC is sent back to Case Management Agency's Nurse Home Visitor Supervisor.
- Closure done by CM Nurse Home Visitor at child's second birthday. Closure is submitted to SRI.
- NOTE: Case Management Agency and SRI work together throughout process to ensure that outstanding PA numbers have been reconciled.

Personal Care Attendant (PCA) Waiver Overview of the Entry Process

Step 1
BCSS/Contractor (SRI)

- ✓ Requestor accepts waiver opportunity
- ✓ FOC is sent and completed
- ✓ Send all (if any) waiver criteria documentation to PCA Waiver Agency with Linkage info
- ✓ Send notification/listing to BCSS RO re: linkage

Step 2
PCA Waiver Agency

- ✓ Receives linkage info with any assessment info that validates they have met the waiver criteria
- ✓ Contacts requestor within three calendar days of notification of linkage
- ✓ Obtain documentation of disability (Medical History w/diagnosis or SSI approval)
- ✓ Assists individual with obtaining a 90-L that states disability; if disability met then proceed. If disability is not met, contact BCSS R.O.
- ✓ Complete MDS-HC
- ✓ Sets CPOC appointment with requestor & authorized representative if applicable

Step 3
PCA Waiver Agency

- ✓ CPOC finalized & signed by requestor, Authorized Representative,& others that attend the planning meeting
- ✓ At CPOC meeting, the following forms should be explained: Rights & Responsibilities, Waiver Fact Sheet, Medicaid Services Chart, and Help Line
- ✓ Submits a complete CPOC packet to BCSS R. O. within 35 calendar days of linkage
- ✓ Financial application sent to BHSF Parish Office

Step 4
BCSS Regional Office

- ✓ Receives CPOC Packet (return if incomplete)
- ✓ Review MDS-HC prior to home visit
- ✓ Conducts pre-certification home visit & Provides information on informed choice
  - Validates that they have been given/signed:
    - Rights & Responsibilities Forms
    - Authorized Representative - if applicable,
    - Waiver Fact Sheet, Medicaid Services, and Help Line have been explained
- ✓ Issues approved 142 to BHSF Parish Office only

Step 5
BHSF Medicaid Parish Office

- ✓ Financial Eligibility determined
- ✓ 18W issued for approval or disapproval

Step 6
BCSS Regional Office

- ✓ After receipt of the 18W, the 51NH is completed with the admission date the same as on the 18W and 142, but the payment begin date will be the date the 51NH is completed.
- ✓ CPOC begin date is 18W and the end date is
- ✓ Copies of the approved 142, 51NH, and CPOC are sent to the PCA Waiver Agency (Recipient receives 142 only)
- ✓ Copy of the 51-NH, CPOC demographic, budget, & approval pages, to SRI for prior authorization

Step 7
PCA Waiver Agency

- ✓ Sends a copy of the approved CPOC to the recipient
- ✓ Implements the CPOC PCA Services as outlined
- ✓ Case Management component shall review individual as needed , but no less than quarterly

Step 8
PCA Waiver Agency

- ✓ Must have at a minimum, quarterly face-to-face home visits
- ✓ High Need requires monthly visits
- ✓ Annual CPOC completed and submitted to BCSS Regional Office no less than 35 calendar days prior to expiration
- ✓ Send 148 to BHSF Parish Office, BCSS, and SRI on changes in address, closures, etc.

BUREAU OF COMMUNITY SUPPORTS AND SERVICE HELPLINE

TOLL FREE PHONE NUMBER

1-800-660-0448

This line is manned M-F 8:00 a.m - 4:30 p.m.

Providers, recipients, friends or family may access this line to report any problems, abuse, neglect etc.

REVISED 07-19-01

KARNOFSKY PERFORMANCE SCALE

Definition: This assessment tool is used to assist clinicians and caretakers to measure the patient's ability to carry out activities of daily living, and should be noted at each patient visit. Documentation of Karnofsky score may also be helpful if patient applies for disability benefits.

DESCRIPTION	PERCENT(%)
Normal; no complaints; no evidence of disease	100
Able to carry on normal activity; minor signs and symptoms of disease	90
Normal activity with effort; some signs and symptoms of disease	80
Cares for self; unable to carry on normal activity or do work	70
Requires occasional assistance, but is able to care for most personal needs	60
Requires considerable assistance and frequent medical care	50
Disabled; requires special care and assistance	40
Severely disabled; hospitalization indicated although death not imminent	30
Very sick; hospitalization necessary; requires active support treatment	20
Moribund; fatal processes progressing rapidly	10

CASE MANAGER'S MONITORING CHECKLIST OF SERVICE PROVIDERS

Recipient Name: Recipient Medicaid #: Region: Date:			Case Manager: Address: Phone:	
Name and Address of Service Provider:			Service Provider Director: Phone:	
Agency/Home Requirements	Response		Comments	Corrective Action
CPOC Compliance	Yes	No		
THE AGENCY HAS A SERVICE PLAN WHICH DESCRIBES THE SERVICES TO BE DELIVERED.				
DO THE DATES ON THE SERVICE PLAN MATCH THE CPOC?				
THE AGENCY SERVICE PLAN IS IN COMPLIANCE WITH THE CPOC AND DESCRIBES STRATEGIES FOR COMPLETING DESIGNATED OUTCOMES.				
THE AGENCY HAS DAILY LOGS IN THE HOME THAT REFLECT SERVICE DELIVERY IN ACCORDANCE WITH THE CPOC.				
IS EACH ENTRY ON SERVICE PROVIDERS PROGRESS NOTES DATED, SIGNED, AND LABELED WITH RECIPIENT NAME?				
IS ERROR CORRECTION PROCEDURE FOLLOWED?				

IS THE SERVICE PROVIDER'S CLIENTS RIGHTS FORM MAINTAINED IN RECIPIENT'S RECORD?				
IS ACCESS TO RECORDS SIGNED AND DATED BY EACH REVIEWER?				
HAVE YOU BEEN NOTIFIED OF THE SERVICE PROVIDER'S CONFIDENTIALITY POLICY?				
ARE THE SERVICES DELIVERED AT CONVENIENT TIMES AND ARE THEY SATISFACTORY TO YOU?				
HAS THE SUPERVISOR FOR THE SERVICE PROVIDER AGENCY CONTACTED YOU DURING THE PAST THREE MONTHS TO CHECK IF SERVICES ARE BEING PROVIDED AS NEEDED?				
IS THERE A CURRENT PROGRESS NOTE FOR EACH SERVICE PROVIDER IN THE HOME?				
WHERE IN THE HOME IS THE BOOK WITH THE SERVICE PLAN, NOTES, TIME SHEETS, CPOC, 90-L, SOCIAL, AND PSYCH KEPT?				

HAS THE CASE MANAGER REMINDED THE FAMILY/RECIPIENT OF THE IMPORTANCE OF THE BOOK AND NEED TO KEEP IT IN AN AREA WHERE IT CAN BE MAINTAINED, AS IT IS A NECESSARY PART OF HOME-BASED SERVICES?				
IS THE SHIFT TIME NOTED ON THE PROGRESS NOTE?				
IS THERE A TIME SHEET IN THE HOME?				
DOES THE TIME SHEET MATCH THE CPOC?				
DO YOU AGREE THAT THE SERVICE PROVIDER ARRIVES AND LEAVES ACCORDING TO THE PROGRESS NOTE/TIME SHEET?				
IF YOU HAVE A COMPLAINT ABOUT YOUR SERVICE PROVIDER, DOES IT GET RESOLVED?				

	Response		Comments	Corrective Action
Health and Safety	Yes	No		
DO YOU REQUIRE A SPECIAL NEEDS SHELTER?				
DOES THE SERVICE PROVIDER AGENCY MAINTAIN A CURRENT INDIVIDUALIZED EMERGENCY PREPAREDNESS PLAN FOR YOU?				

IS THERE A COPY OF THIS PLAN IN THE HOME?				
IS THERE A CURRENT EVACUATION PLAN IN THE HOME?				
ARE TOLL FREE NUMBERS TO CM AGENCY AND SERVICE PROVIDER AND WAIVER HELP LINE AND 911/OTHER EMERGENCY ACCESS AVAILABLE TO YOU?				
DID THE CASE MANAGER REVIEW THESE NUMBERS FOR ACCURACY?				
DID CASE MANAGER CHECK PERS IF APPLICABLE?				
ARE THERE SMOKE DETECTORS, FIRE ESTINGUISHER, FIRST AID SUPPLIES IN HOME AND IS HOME FREE FROM SAFETY HAZARDS?				
	Response	Comments	Corrective Action	
Health and Wellness	Yes	No		
HAVE YOUR NEEDS BEEN MET IN THE FOLLOWING AREAS? a. LIVING SITUATIONS b. HEALTH/MEDICAL SUPPORT DO YOU RECEIVE HOME HEALTH SERVICES? IS THERE A COPY OF THE HOME HEALTH PLAN OF CARE IN THE HOME?				

c. RELATIONSHIPS d. DAILY ACTIVITIES e. WORK AND SCHOOL f. STAFF SUPPORT				
HAVE YOUR HEALTH CARE ISSUES AND CONCERNS BEEN ADDRESSED TO YOUR SATISFACTION?				
IS THERE A PHYSICIAN'S DELEGATION MEDICATION ADMINISTRATION FORM IN THE HOME?				
DOES IT MATCH WHAT YOU ARE ACTUALLY TAKING?				
IS THERE A FORM FOR EACH WORKER/AGENCY ADMINISTERING MEDS?				
DO YOU RECEIVE MEDICAL PROCEDURES/TREATMENTS SUCH AS NEBULIZERS/TUBE FEE DRIP/ ETC?				
DO YOU HAVE ACCESS TO ADEQUATE MEDICAL SERVICES SUCH AS DENTAL/SPECIALISTS, ETC?				
HAVE YOU BEEN HURT BY ANYONE IN THE LAST THREE MONTHS?				
DO YOU THINK YOUR WORKER KNOWS HOW TO TAKE CARE OF YOU?				

	Response		Comments	Corrective Action
Rights	Yes	No		
IS THE WAIVER RIGHTS/RESPONSIBILITIES FORM IN YOUR HOME?				
DO YOU KNOW YOUR RIGHTS?				
ARE YOU TREATED FAIRLY?				
DO YOU KNOW WHO TO CONTACT WITH A COMPLAINT ABOUT YOUR WAIVER SERVICES?				
DO YOU KNOW WHO TO CONTACT IF YOUR HEALTH CHANGES?				
DO YOU CONTACT YOUR CM IFYOU MOVE OR CHANGE YOUR PHONE NUMBER/MAILING ADDRESS?				
DO YOU LET YOUR CASE MANAGER KNOW IF THE PEOPLE YOU LIVE WITH CHANGE?				
DO YOU KNOW WHO TO CONTACT IF YOU ARE UNHAPPY WITH YOUR CASE MANAGER?				
DO YOU FEEL YOUR GOALS/NEEDS ARE MET?				

Personal Outcomes	Response		Comments	Corrective Action
Autonomy/Affiliation/Attainment	Yes	No		
1. DOES ANYONE GET YOUR CONSENT BEFORE SHARING PERSONAL INFORMATION?				
2. HAVE HOME MODIFICATIONS BEEN ADDRESSED TO MAKE YOUR HOME ACCESSIBLE?(i.e. ramp, lift)				
3. DID YOU PARTICIPATE IN THE COMPREHENSIVE PLAN OF CARE MEETING?				
4. ARE YOU SATISFIED WITH YOUR PARTICIPATION AND INTERACTION WITHIN THE COMMUNITY?				
5. IS TRANSPORTATION AVAILABLE AND RELIABLE WITHIN THE COMMUNITY?				
6. DO YOU GET TO SPEND ENOUGH TIME WITH YOUR FAMILY AND FRIENDS?				
7. DO YOU HAVE ENOUGH FRIENDS OR WOULD YOU LIKE MORE?				
8. DO PEOPLE LISTEN TO YOUR COMMENTS AND CONCERNS?				
9. DID THE CASE MANAGER OR OTHER PERSONS EXPLAIN WHAT CHOICES OF SERVICES ARE AVAILABLE?				

10. WERE YOU GIVEN A CHOICE OF SERVICE PROVIDERS?				
11. HAVE YOU ACCOMPLISHED ANYTHING IN THE LAST TWO YEARS THAT IS IMPORTANT TO YOU?				
12. HAVE NATURAL SUPPORTS BEEN IDENTIFIED AND UTILIZED?				
13. ARE THE SERVICES YOU RECEIVE THE ONES YOU REQUESTED?				
14. ARE YOU SATISFIED?				
Person(s) interviewed and their title:				
Reviewer Signature:		Title:		Date:

Comments:

Bureau of Community Supports and Services

Rights and Responsibilities for Applicants / Recipients of a Home and Community Based Waiver

These are your **rights** as an applicant for or a recipient of a Home and Community Based Waiver:

- To be treated with dignity and respect.
- To participate in and receive person-centered, individualized planning of supports and services.
- To receive accurate, complete, and timely information that includes a written explanation of the process of evaluation and participation in a Home and Community Based Waiver, including how you qualify for it and what to do if you are not satisfied.
- To work with competent, capable people in the system.
- To file a complaint, grievance, or appeal with a case management agency, direct service provider, or the Department of Health and Hospitals regarding services provided to you if you are dissatisfied. Please call our Help Line at 1-800-660-0488.
- To have a choice of service/support providers when there is a choice available.
- To receive services in a person-centered way from trained, competent care givers.
- To have timely access to all approved services that are identified in your Comprehensive Plan of Care (CPOC).
- To receive in writing any rules, regulations, or other changes that affect your participation in a Home and Community Based Waiver.
- To receive information explaining case manager and direct service provider responsibilities and their requirements in providing services to you.
- To have all available Medicaid services explained to you and how to access them **if you are a Medicaid recipient.**

These are your **responsibilities** as an applicant for or recipient of a Home and Community Based Waiver:

- To actively participate in planning and making decisions on supports and services you need.
- To cooperate in planning for all the services and supports you will be receiving.
- To refuse to sign any paper that you do not understand or that is not complete.
- To provide all necessary information about yourself. This will help the case manager to develop a Comprehensive Plan of Care (CPOC) that will determine what services and supports you need.
- To not ask providers to do things in a way that are against the laws and procedures they are required to follow.
- To cooperate with the Bureau of Community Supports and Services' staff and your case manager by allowing them to contact you by phone and visit you in your home at least quarterly. Necessary visits include pre-certification visits to assist the Bureau in providing the best services and supports possible, regular home visits to assure your plan of care is sufficient to meet your needs, visits resulting from complaints to BCSS, and visits needed to assure you are receiving the services as reported by your providers.
- To immediately notify the case manager and direct service provider who works with you if your health, medications, service needs, address, phone number, alternate contact number, or your financial situation changes.
- To help the case manager identify any natural and community supports that would be of assistance to you in meeting your needs.
- To follow the requirements of the program, and if information is not clear, ask the case manager or direct service provider to explain it to you.
- To verify you have received the waiver and medical services the provider says you have received, including the number of hours your direct care provider works, and report any differences to the BCSS Help Line at 1-800-660-0488.

Responsibilities as an applicant for or recipient of a Home and Community Based Waiver (continued):

- To understand as a recipient of the waiver program, if you fail to receive waiver services for thirty (30) days or more your waiver case may be closed.
  - In the ADHC waiver, case management is not a separate service and the recipient must receive services at the ADHC facility.
  - In the PCA waiver, case management is not a separate service and the recipient must receive PCA services.
  - In the MR/DD waiver, case management is not a waiver service and does not apply as a service in the thirty (30)-day rule.

  The thirty (30)-day continuity of care rule does not apply to hospital days.

- To obtain BHSF Form 90-L "Request for Level of Care Determination" completed by your physician each year. Failure to provide this form at least 35 days prior to your annual Comprehensive Plan of Care may result in you becoming ineligible to receive further waiver services. Applicants and recipients for MR/DD and Children's Choice services must also provide a psychological assessment periodically as requested to continue to be eligible for services.

- To understand that all waiver programs have an age requirement, and that you will not be offered services in a program that you previously requested if you no longer meet the age requirement for that program.

- To request different waiver services if you no longer meet any of the criteria as outlined on the waiver fact sheet that you received.

Bureau of Community Supports and Services

Rights and Responsibilities for Applicants / Recipients of a Home and Community Based Waiver

I have read and understand my rights and responsibilities for applying for / participating in a Home and Community Based Waiver. I also understand the reasons that may cause me to lose these supports and services for me or the person whom I am authorized to represent in this matter.

☐ I understand as a recipient of the waiver program, if I fail to receive waiver services for thirty (30) days or more I may have my waiver case closed.

- In the ADHC waiver, case management is not a separate service and I must receive services at the ADHC facility.
- In the PCA waiver, case management is not a separate service and I must receive PCA services.
- In the MR/DD waiver, case management is not a waiver service and does not apply as a service in the thirty (30)-day rule.

The thirty (30)-day continuity of care rule does not apply to hospital days.

☐ **As a Medicaid recipient,** I understand the Medicaid services available to me and how to receive them. (Medicaid recipients ONLY, please check the box.)

APPLICANT/RECIPIENT NAME: _____

_____ _____

Signature of Applicant/Recipient or Authorized Representative — Date

_____ _____

Case Manager — Date

_____ _____

BCSS Representative — Date

Case Management Quarterly Data Reporting Form

Quarter Ending _____

Agency Demographics

Agency Name		Provider Number	
Address		Telephone	
City		Region	
State	Zip	License Expires	
Email Address		Onsite Project Manager	

Caseload Data

Beginning Caseload		Number of linked cases at the beginning of the quarter.
Cases Opened		Number of cases linked during the quarter.
Cases Closed		Number of cases closed during the quarter.
Ending Caseload		Number of linked cases at the end of the quarter.
Non-Medicaid Cases		Number of non-Medicaid cases during the quarter.

Caseload Breakdown

Breakdown of all case types during the quarter. This would include both Medicaid and Non-Medicaid cases.

Nurse Home Visits		Infant Toddlers - Medicaid	
HIV Infected (Medicaid)		MR/DD Waiver	
Ryan White (Non-Medicaid)		Elderly Disabled Adult Waiver	
Infant and Toddlers - Non-Medicaid		Children's Choice Waiver	
		EPSDT Targeted	

Case Manager Data

All items in this section should reflect the status as of the last day of the quarter.

Case Managers - Medicaid		Number of case managers who manage only Medicaid cases.
Case Managers - Non-Medicaid		Number of case managers who manage only Non-Medicaid cases.
Case Managers - Both		Number of case managers who manage both Medicaid and Non-Medicaid cases.
Part-time Case Managers		Number of part-time case managers employed with the agency.
Maximum Caseload		Number of case managers employed with caseloads which exceed thirty-five (35). (Include non-medicaid)
Case Manager Supervisors		Number of case manger supervisors employed with this agency.
Supervisor Caseload		Number of cases carried by case manager supervisors.
Supervision		Number of case manager supervisors who supervise more than eight (8) full time case mangers or other professional level human services staff.
Internal Training		Number of hours of training provided for case managers.
Orientation Training		Of the total number of hours of provided for case managers, indicate how many were for orientation.
New Employees		Number of new employees during the quarter.

Case Management Quarterly Data Reporting Form

Comprehensive Plan of Care Data

Initial CPOC's Completed & Submitted		Number of initial Comprehensive Plans of Care (CPOC's) completed and submitted to BCSS during the quarter.
Initial CPOC's Not Approved		Number of initial CPOC's not approved by BCSS within 35 days during the quarter.
Contact Within 10 Days		Number of cases with documented contact with recipient within 10 days after CPOC is approved to assure appropriateness and adequacy of service.
Services Found Not To Be Provided		Number of services found not to be provided as per the CPOC as a result of case management monitoring.
		Number of services found not to be provided at all.
Natural Supports		Number of CPOC's completed with natural supports included during the quarter.
Personal Outcomes		Number of CPOC's completed with personal outcomes included during the quarter.
Annual CPOC's Due		Number of annual CPOC's due during the quarter. (35 days prior to expiration)
Completed Annual CPOC's Submitted Timely		Of the CPOC's due this quarter, the number submitted 35 days prior to the expiration of the CPOC.
Non-Emergency CPOC Revisions		Number of CPOC revisions during the quarter as a result of non-emergency situations such as holidays, vacations, provider change, etc.
Emergency CPOC Revisions		Number of CPOC revisions during the quarter as a result of emergency situations such as illness, death of immediate family member, etc.
Direct Service Providers		Number of family members who become direct service providers during the quarter.

Other Documentation

Face-To-Face Visits		Number of cases which have met face-to-face requirement during the quarter. (non-waiver population)
Home Visits Required (Eldery & MRDD)		Number of cases with home visit required during the quarter for elderly and MRDD cases.
Home Visits Done (Elderly & MRDD)		Number of cases with home visists done during the quarter.
Health/Safety Issues Implemented		Number of health/safety issues addressed in Initial/Annual CPOC's which were impemented during the quarter.
Consumer Satisfaction Surveys Completed		Number of consumer satisfaction surveys completed during the quarter.
Complaints Received		Number of complaints received by the agency during the quarter.

Categorize complaints received during the quarter:

Administrative (DHH) ____ Service Related ____ Provider Related ____ CM Agency Related ____ Health/Safety Related ____ Other ____

Complaints Resolved		Number of complaints resolved during the quarter.
Incidents Reported		Number of incidents reported during the quarter.

Categorize incidents reported during the quarter:

Health/Safety Related ___ Family Related ____ Provider Related ____ Abuse/Neglect Related ____

Incidents Reported To Authorities		Number of incidents reported to BCSS that also required reporting to other authorities.
Recipient Deaths		Number of recipient deaths in the quarter.
Primary Care Givers' Deaths		Number of primary care givers' deaths during the quarter.

Name _____

APPENDIX D

COMPLAINT PROCEDURES

CRITICAL INCIDENT REPORTING FORM
INCIDENT/COMPLAINT REPORTING FOR CASE MANAGERS AND SERVICE PROVIDERS:
- IMMINENT DANGER OF SERIOUS HARM
- INTERNAL COMPLAINT PROCESS
- COMPLAINT DISCLOSURE STATEMENT
- DEFINITION OF TERMS

Department of Health and Hospitals
BCSS Critical Incident Reporting System

❑ **Initial Notification** (within 2 hours of notification)	❑ **Preliminary Report** (within 72 hours of notification)	❑ **Final Report** (within 30 days)

RECIPIENT IDENTIFYING INFORMATION:	
Name:	DOB:
SSN	Medicaid #
Waiver Type: ❑ MR/DD ❑ EDA ❑ PCA ❑ ADHC ❑ CC	Institutional Transition: ❑ Yes ❑ No
History of Health Concerns: ❑ Yes ❑ No	History of Abuse/Neglect: ❑ Yes ❑ No
Name of Family/Legal Guardian:	Phone#
Address:	

CLASSIFICATION OF INCIDENT:					
❑ Abuse (physical, emotional, sexual) SEXUAL *Circle Type of Abuse*	❑ Neglect	❑ Exploitation	❑ Extortion	❑ Illness	❑ Death
❑ Physical Injury (requiring more than First Aid up to emergency hospitalization)					
❑ Sensitive Situation:					
❑ Missing/Whereabouts Unknown	❑ Other _____				

INCIDENT INFORMATION:		
Place of Occurrence:	Date:	Time:
Names of Individuals with Recipient (*include relationship*) at Time of Incident:		
Initial Notification: ❑ APS ❑ OCS ❑ EPS ❑ Legal Systems ❑ Other (Specify)_____		
If hospitalized (*emergency room or admission*), name of attending physician:		
Hospital Name/Address:		

CASE MANAGEMENT AGENCY:	
Case Manager Name:	Phone #:

DIRECT SERVICE PROVIDER AGENCY:	
Contact Person:	Phone #:

Report Completed by:	**Ph#:**	**Date:**	**Region:**

(Narrative Report MUST Be Attached)

Issued 06/07/01

BCSS Critical Incident Report - Narrative

RECIPIENT NAME:	
SSN	MEDICAID #

CURRENT SITUATION:

Report Completed by:	**Ph#**	**Date:**	**Region:**

Issued 06/07/01

INCIDENT/COMPLAINT REPORTING FOR CASE MANAGERS AND SERVICE PROVIDERS

The case management agency and the direct service provider are responsible for ensuring the health and safety of the recipient. Recipients shall be free to file a complaint or grievance regarding their case manager or service provider without fear of reprisal.

IMMINENT DANGER OR SERIOUS HARM

1. Call 911 for emergency help or the local law enforcement agency;

2. For children under the age of 18, call the local Child Protection Hotline;

3. For recipients age 18 or emancipated minors, call the Bureau of Protective Services at 1-800- 898-4910 or (225) 922-2250;

4. Initiate an internal investigation; and

5. Contact the BCSS Complaint Manager within 24 hours at 1-800-660-0488 or by writing the following address:

BCSS Complaint Manager
446 N. 12th Street
Baton Rouge, LA 70802
1-800-660-0488

- The service provider shall also let the case manager know of all incidents/abuse/complaints.

INTERNAL COMPLAINT PROCESS

Less serious complaints are to be handled through the provider's internal complaint process.

- Each agency shall appoint a complaint coordinator to investigate complaints.

- If the complaint is verbal, the provider staff member receiving the complaint must obtain all pertinent information and send all pertinent information in writing to the provider complaint coordinator. If the recipient completes the complaint form, he/she will be responsible for sending the form to the provider complaint coordinator.

- The complaint coordinator shall acknowledge in writing within five (5) working days the receipt of the recipient's complaint.

- The complaint coordinator must thoroughly investigate each complaint using existing policy. The investigation includes but is not limited to the gathering of facts from the recipient and other services providers. These contacts may be either in person or by the telephone. The provider is encouraged to use all available resources to resolve the complaints at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution.

- The provider's administrator or designee must inform the recipient in writing within ten (10) working days of the results of the internal investigation.

- The recipient must be informed that if he/she is dissatisfied with the results of internal investigation he/she may continue the grievance process within thirty (30) calender days by contacting the BCSS Complaint Manager. The complaint manager can be contacted at:

  BCSS Complaint Manager
  446 N. 12th Street
  Baton Rouge, LA 70802
  1-800-660-0488

- The BCSS State Office Complaint Personnel will notify the complainant within ten (10) work days that the complaint has been received and is being investigated, if the complainant's name and address are known.

COMPLAINT DISCLOSURE STATEMENT

La. R.S. 40:2009.13 - .21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the Home and Community-Based Services waiver programs. When the substance of the complaint is furnished to the service provider, it shall not identify the complainant or the recipient unless he/she consents in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

- The BCSS State Office Complaint Program Manager or other BCSS Complaint Personnel may determine when the complaint is initiated that a disclosure statement is necessary. In addition, the BCSS Regional Office staff may also

determine that a disclosure statement may be necessary.

- If the BCSS Regional Office staff determines a Complainant Disclosure Statement is necessary, they will contact the BCSS State Office Complaint Personnel who will inform the complainant and give them an opportunity to withdraw the complaint.

- If the complainant still elects to file the complaint, the BCSS State Office Complaint Personnel will mail or FAX the disclosure form to the complainant with instructions for them to return it to State Office.

- A copy will be Faxed to the BCSS Regional Office staff upon receipt, and further investigation will continue.

DEFINITION OF RELATED TERMS REGARDING COMPLAINTS

For the purposes of the Bureau of Community Supports and Services complaint process, the words "complaint" and "grievance" will be used synonymously. The following definitions will be used:

- 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)

- Minimal harm - is 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)

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

- Allegation of noncompliance - is 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)

- Abuse - is 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)

- Exploitation - is 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 - is 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)

- Neglect - is the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other 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)

- Self-neglect - is 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)

- Sexual abuse - is 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.

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

- Incident - any situation involving a recipient that is not classified in one of the other categories but indicates the need for awareness by BCSS as it could have some affect on the recipient or the recipient's ability to benefit from their supports and services now or at some time in the future.

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

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

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SECRETARY

MEMORANDUM

TO: Support Coordination and Direct Service Provider Agencies Providing Support to the New Opportunities and Children's Choice Waiver Participants

FROM: Kathy H. Kliebert
Assistant Secretary

SUBJECT: Personal Outcome Measures Training

DATE: January 18, 2006

OCDD will begin offering Personal Outcome Measures (POM) to OCDD Regional Offices, Support Coordination Agencies and Direct Service Providers in March. The following are the trainings that will be offered:

One day "refresher" for:

- People who have had the 2 or 4 day session and want a refresher.
- People who need to know what POMs are, but do not work directly with people supported, i.e., Administrators of Regional Offices, Support Coordination Agencies and Direct Service Provider Agencies and other OCDD staff who would like to know what POMs are all about.

Three day session for:

- People who have never been introduced to the outcomes and need the skills of gathering the information for people supported, i.e., QMRPs, Direct Support Workers, Support Coordinators, Regional Office staff, etc.

  This session is two days in classroom learning and one day meeting with someone in services to gather information about their personal outcomes. Day one and three are classroom and day two is with the person.

In order to effectively plan for these trainings, we need an assessment of your training needs for Personal Outcome Measures. So that we can begin the process of prioritizing the locations and dates the trainings will occur, please complete the attached Training Needs for Personal Outcome Measures. **This information is to be returned via mail, fax or e-mail, no later than Friday, February 10, 2006** to:

Office for Citizens with Developmental Disabilities
Attn: Joyce Louden, Education and Training Manager
P. O. Box 3117
Baton Rouge, LA 70821-3117
Fax: 225-342-8823
e-mail: jlouden@dhh.la.gov

For your information, we will begin scheduling these trainings as follows:

March 8, 2006 and March 9, 2006 – One day "refreshers"
Weeks of March 13, 2006 and March 27, 2006 – Three day sessions

Please be aware that this is the first of many that will be offered and not all agencies/regions will be able to attend these first trainings. The information you provide on the Training Needs form will determine the locations and dates of these sessions. You will receive the official dates, times and locations of these sessions and subsequent sessions as they are scheduled.

Additionally, for your information, we will also be providing Planning Framework training beginning sometime in May. We will be gathering information relative to that training sometime in the near future.

We appreciate your assistance in providing our participants the services they need.

KHK:eb

attachment

Training Needs
For
Personal Outcome Measures

Organization/Agency: _____

Address: _____

Telephone Number: _____ **Region:** _____

E-Mail Address: _____

Contact Person: _____

Check Organization Type:

___Regional Office ___Private Support Coordination Agency

___Direct Service Provider

Indicate the number of people who need to attend a Personal Outcome Measures Session

One Day "Refresher": _____

Three Day: _____

Return to:

Office for Citizens with Developmental Disabilities
Attn: Joyce Louden, Education and Training Manager
P. O. Box 3117
Baton Rouge, LA 70821-3117
FAX: 225-342-8823
e-mail: jlouden@dhh.la.gov

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

MEMORANDUM

Date: March 23, 2007

To: Medicaid Enrolled Hospice, Wavier and Support Coordination Providers

From: Jerry Phillips
Medicaid Director

Hugh Eley
OAAS Assistant Secretary

Re: Waiver/Hospice Concurrent Care

In 2005 the Department of Health and Hospitals (DHH) clarified our policy regarding Hospice and Wavier services provided concurrently. At that time, DHH began to require recipients to forfeit their waiver services if they chose to elect hospice services. This decision was made because Medicaid administration was concerned about the possibility of duplication of services and payment in both programs.

DHH is pleased to announce that this policy has been reversed. Effective May 1, 2007, recipients may receive both hospice and waiver services concurrently. However, both hospice and waiver providers must work together to ensure that no services are duplicated. To ensure the integrity of both programs, Medicaid and OAAS collaborated to craft policy designed to reduce the possibility of duplication. Both Hospice and Waiver Providers must adhere to this policy when providing services to a Medicaid recipient that is receiving both services. This includes recipients who have both Medicare/Private Insurance and Medicaid.

If you have questions please contact Randy Davidson at (225) 342-4818.

Attachment

Hospice Waiver Recipients Policy

I. Medicaid Waiver Recipients and Hospice Services

Recipients who receive home and community-based services through one of the waiver programs offered by OAAS or OCDD are also eligible for Medicaid hospice services. These waiver programs are:

Adult Day Health Care (ADHC) Waiver
Elderly and Disabled Adult (EDA)Waiver
New Opportunities Waiver (NOW)
Children's Choice Waiver (CCW)
Supports Waiver (SW)
Note: Long Term Personal Care Services (LT PCS) is a Medicaid State Plan Service and not a waiver service; LT PCS recipients may not receive hospice services while receiving LT PCS.

II. Service Coordination

Medicaid expects the hospice provider to interface with other non-hospice providers depending on the need of the recipient to ensure that the recipient's overall care is met and that non-hospice providers do not compromise or duplicate the hospice plan of care. This expectation applies to Medicaid hospice recipients and Medicare/Medicaid hospice recipients. The hospice provider must ensure that a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid recipient to identify all other Medicaid or other state and/or federally funded program providers of care.

Medicaid waiver recipients who elect the hospice benefit do not have to disenroll from the waiver program, but they must be under the direct care of the Medicaid hospice provider for those services both programs have in common. The waiver member who elects the hospice benefit can still receive waiver services **that are not related to the terminal hospice condition and are not duplicative of hospice care**. The hospice provider and the waiver support coordinator must collaborate and communicate regularly to ensure the best possible overall care to the waiver/hospice member. These collaborative sessions must be documented in both the hospice and waiver case manager/support coordinator progress notes. Failure to collaborate may result in administrative sanctions.

Guidelines for hospice and waiver providers include the following:

- The hospice provider, waiver provider and waiver case manager must meet to develop a coordinated plan of care.
    - The hospice provider must prepare the hospice plan of care to include all services that the hospice provider would have covered to treat the terminal illness and related conditions had the Medicaid recipient not been on the waiver program.

- The waiver provider must prepare the waiver plan of care to include all services that the waiver provider would have covered had the Medicaid recipient not been on the hospice program.

- The waiver providers must then modify the waiver plan of care to ensure there is no duplication of services by the waiver provider for those services held in common that would be necessary to treat the terminal illness and related conditions. For example, the waiver provider must modify or adjust hours in the waiver plan of care if the hospice agency must provide personal care, attendant care, or homemaker hours to treat the terminal condition that the waiver provider would otherwise provide if the recipient had not elected hospice services.

- Different diagnoses for the respective hospice and waiver plans of care are not sufficient to ensure that there is no duplication of services. Medical records of each provider may demonstrate that a patient's primary hospice diagnosis and patient's waiver diagnosis intermingle to such a degree that it is not possible to differentiate between the waiver diagnoses and the hospice primary diagnoses.

- The fact the hospice provider and the waiver provider are in the member's home at different times is not sufficient to ensure that there is no duplication.

- Both providers must thoroughly document the required distinction between the services provided.

- The hospice provider shall be responsible for providing those services that intermingle between diagnoses. Approved waiver services shall be reduced by the appropriate level.

The hospice provider's failure to include all necessary hospice core services in the hospice plan of care for the waiver/hospice recipient subjects the hospice provider to recoupment when overpayment or duplication is identified.

III. Inquiries

Inquiries to DHH about policy clarification for the coordination of care for waiver recipients who are dually-eligible and receive Medicare hospice benefit are handled by referring the Medicare hospice to the Medicare fiscal intermediary. While Medicaid is the payor of last resort and must not under any circumstances pay for waiver services that are duplicative of Medicare hospice care, DHH has no authority to instruct a Medicare hospice provider about Medicare hospice plan of care modifications. The hospice provider must obtain clarification from Medicare.

All inquiries to DHH from waiver providers regarding coordination of hospice and waiver services will be handled by either OAAS or OCDD. Inquiries from hospice providers about the provision of Medicaid Hospice services will be handled by Medicaid Hospice staff.