



NEW OPPORTUNITIES WAIVER (NOW) PROVIDER MANUAL

Chapter Thirty-two of the Medicaid Services Manual

Issued March 1, 2011

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

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

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OVERVIEW

The New Opportunities Waiver (NOW) program is a Medicaid waiver designed to provide home and community-based supports and services to recipients with developmental disabilities who require the level of care of an Intermediate Care Facility for people with Developmental Disabilities (ICF/DD). This waiver is operated by the Office for Citizens with Developmental Disabilities (OCDD) under the authorization of the Bureau of Health Services Financing (BHSF). Both OCDD and BHSF are agencies within the Louisiana Department of Health and Hospitals (DHH).

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

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

Recipients have the choice of available support coordination and service provider agencies and are able to select enrolled qualified agencies through the freedom of choice process. NOW services are accessed through the recipient's support coordinator and are based on the individual needs and preferences of the recipient. A support team, which consists of the recipient, support coordinator, recipient's authorized representative, appropriate professionals/service providers, and others whom the recipient chooses, is established to develop the recipient's Plan of Care through a person-centered planning process. The Plan of Care contains all services and activities involving the recipient, including non-waiver services as well as waiver support services. The completed Plan of Care is submitted to the OCDD regional waiver office for review and approval.

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

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SECTION 32.0: OVERVIEW

This chapter is intended to give a NOW provider the information needed to fulfill its vendor agreement with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and DHH rules.

COVERED SERVICES

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

Recipients must receive at least one NOW service every 30 days.

Individual and Family Support

Individual and Family Support (IFS) services are defined as direct support and assistance provided to a recipient in his/her home or in the community that allow the recipient to achieve and/or maintain increased independence, productivity, enhanced family functioning, and inclusion in the community or for the relief of the primary caregiver. IFS services may not supplant primary care available to the recipient through natural and community supports.

IFS services include the following allowable activities:

- Assistance and prompting with personal hygiene, dressing, bathing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated.
- Assistance and/or training in the performance of tasks related to maintaining a safe, healthy, and stable home, such as
 - Housekeeping,
 - Laundry,
 - Cooking,
 - Evacuating the home in emergency situations,
 - Shopping, and
 - Money management, which includes bill paying.
- Assistance in participating in community, health, and leisure activities which may include accompanying the recipient to these activities.
- Assistance and support in developing relationships with neighbors and others in the community and in strengthening existing informal social networks and natural supports.

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- Enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences such as volunteer work and community awareness activities.
- Accompanying the recipient to the hospital and remaining until admission or a responsible representative arrives, whichever occurs first. IFS services may resume at the time of discharge.

The provider must develop an Individualized Service Plan for the provision of IFS services that documents the supports to be provided to the recipient that allows him/her to meet the goals identified on the approved Plan of Care.

Individual and Family Support - Day

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

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

Individual and Family Support - Night

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

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

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

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

- Recipients who are able to notify direct support workers of their need for assistance during sleeping hours.
- The support team assesses the recipient’s ability to awaken staff. If it is determined that the recipient is able to awaken staff, then the approved Plan of Care shall reflect the recipient’s request that the IFS – N worker be allowed to sleep.
- The support team should consider the use of technological devices that would enable the recipient to notify/awaken IFS – N staff. Examples of devices include wireless pagers, alerting devices such as a buzzer, a bell or a monitoring system. If the method of awakening the IFS – N worker utilizes technological device(s), the service provider will document competency in use of devices by both the recipient and IFS – N staff prior to implementation. The support coordinator will require a demonstration of effectiveness of this service on at least a quarterly basis.
- A review shall include review of log notes indicating instances when IFS – N staff was awakened to attend to the recipient and an acknowledgement by the recipient that the IFS – N staff responded to his/her need for assistance timely and appropriately. Any instance that indicates the staff did not respond appropriately will immediately be brought to the attention of the support team for discontinuing the allowance of the staff to sleep.
- Any allegation of abuse/neglect during sleeping hours will result in discontinuing the allowance of the staff to sleep until an investigation is complete. Valid findings of abuse/neglect during night hours will require immediate revision to the Plan of Care.

Shared Supports

IFS – D or IFS –N services can be shared by up to three waiver recipients who may or may not live together when the recipients:

- Have a common IFS provider agency,
- Agree to share services, and
- Assurance is made for each recipient’s health and safety.

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

Shared support in a community-based event requires the direct service worker to maintain proximity with visual and auditory contact, offering hands-on assistance when appropriate. For example, if the worker is with two recipients at the park, the direct service worker may be tossing a ball with one recipient while maintaining visual/auditory contact with another recipient who is sitting on a bench. Any break in contact must be brief.

The decision to share staff must be reflected on the recipients' Plan of Care and based on an individual-by-individual determination with reimbursement rates adjusted accordingly.

Sharing Supports among Roommates

Finding a recipient or recipients to share supports within one's home is based upon the choice and preferences of the recipients involved. Recipients who live together as roommates and who agree to share supports must sign a release of information allowing each recipient's name to be used in the Plan of Care, progress notes, individualized service plan, etc., of the other recipients with whom services are shared.

Plans of Care for recipients sharing supports among roommates must be submitted at the same time to the Office for Citizens with Development Disabilities (OCDD) regional waiver office to allow for concurrent review. Requests sent to the OCDD regional waiver office must include:

- A completed "Documentation for Authorization of Shared Staff and Release of Information for New Opportunities Waiver (NOW)" form for each recipient," (See Appendix D for information on accessing the *Guidelines for Support Planning* found in Section 6 for a copy of this form)
- A Plan of Care for each recipient that includes the names of the roommates in the "Current Living Situation: Information" section and documentation indicating the risks and benefits of sharing supports has been discussed with the recipients, and
- Copies of budget sheets and typical weekly schedules of all recipients who will be sharing supports.

NOTE: Budget sheets and Plans of Care must be consistent between the recipients when supports are shared.

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Sharing Supports among Non-Roommates

Recipients who choose to share supports casually are **not** required to sign a release of information form or list the names of the other recipients on the Plan of Care.

Support coordination agencies and IFS provider agencies must follow the policy specified in the Office for Citizens with Developmental Disabilities *Guidelines for Support Planning*. (See Appendix D for *Guidelines for Support Planning* information)

Transportation

Transportation **is included** in the rate paid to the direct service provider with no specified mileage limit. The provider is not allowed to charge the recipient, his/her family member or others a separate fee for transportation.

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

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

Place of Service

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

- A worker's residence, unless the worker's residence regardless of the relationship, is a certified foster care home.
- A hospital once the recipient has been admitted.
- A licensed congregate setting. A licensed congregate setting includes licensed ICFs/DD, community homes, Center-Based Respite facilities, and Day Habilitation programs.
- Outside the state of Louisiana, but within the United States or its territories, unless there is a documented emergency or a time-limited exception (not to exceed 30 days) which has been prior approved by the OCDD regional waiver office and included in the recipient's Plan of Care.
- Outside the United States or territories of the United States.

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Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide personal care attendant services and enroll as a Medicaid provider for waiver services or be a direct service worker providing support under an authorized Self-Direction option.

Service Exclusions

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

Service Limitations

IFS cannot be billed or provided for during the same hours on the same day as: Day Habilitation, Supported Employment models, Employment-Related Training, Transportation for Habilitation Services, Professional Services, Center-Based Respite, Skilled Nursing Services, and Individualized and Family Support - Night/Shared.

The IFS – D or N worker may not work more than 16 hours in a 24-hour period unless there is a documented emergency or a time limited, non-routine need that is documented in the recipient’s approved Plan of Care. Habitual patterns of a worker providing more than 16 hours of paid services per day will be investigated.

IFS – D services may not exceed 16 hours in a 24 hour period, unless an exception is documented in the recipient’s approved Plan of Care.

IFS – N services must be a minimum of 8 hours for recipients who receive 24 hours of care.

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

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

Authorization for Worker to Exceed 16-Hour Service Limitation

The OCDD regional waiver office may approve Individual and Family Support workers to provide services for more than 16 hours in a 24 hour period, which includes a combination of IFS – D and IFS – N services, in the following circumstances:

- On a non-routine, time limited basis when the primary caregiver is unable to provide care to the recipient outside the regular IFS hours due to the

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hospitalization or death of a family member, emergency with another child or family member, business travel, or other documented need. The definition of time limited is one exception per quarter for up to seven days. Any request beyond this limit would require approval from the OCDD Central Office.

- In emergency situations that could include hurricane, tornado, flooding, or other acts of God.

Requests must be made by the recipient to the support coordinator. Upon notification of the request, the support coordinator is responsible for submitting a revision request to the OCDD regional waiver office by the next business day. Requests must include supporting documentation.

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

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

Center-Based Respite

Center-Based Respite (CBR) service is temporary short-term care provided to a recipient who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver.

The recipient's routine is maintained while receiving CBR service so that he/she is able to attend school, work, or other community activities and outings. Community outings shall be specified in the recipient's approved Plan of Care and shall include activities the recipient would receive if he/she were not in CBR care.

Transportation

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

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Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide respite as a center-based respite facility and enroll as a Medicaid waiver provider.

Service Exclusions

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

Service Limitations

CBR services shall not exceed 720 hours (2,880 1/4 hours units) per recipient per Plan of Care year.

CBR services cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Supported Employment models, Employment-Related Training, Transportation for Habilitation Services, Professional Services, Individual and Family Support–Day/Night/Shared, Skilled Nursing services, or Community Integration and Development.

Both the recipient and the direct service worker must be present for the provider to bill for this service.

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

Community Integration Development

Community Integration Development (CID) facilitates the development of opportunities to assist recipients in becoming involved in their community through the creation of natural supports. The purpose of this service is to encourage and foster the development of meaningful relationships in the community to reflect the recipient's choices and values (e.g., doing preliminary work toward membership in civic, neighborhood, church, and leisure groups).

Objectives outlined in the recipient's Plan of Care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities.

The provider must develop an Individualized Service Plan for the provision of CID, which must document the supports that will be provided to the recipient to meet his/her goals based on the recipient's approved Plan of Care.

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CID differs from Individual and Family Support (IFS) services in that CID is used for the development of community connections.

To utilize this service, the recipient may or may not be present as identified in the approved CID service plan.

Shared Supports

CID services may be performed by shared staff for up to three waiver recipients who have a common direct service provider agency. Based on a recipient's individual determination, the shared staff shall be reflected in each recipient's approved Plan of Care as a special billing code, and rates should be adjusted accordingly.

Recipients who agree to share supports must sign a release of information allowing each recipient's name to be used in the Plan of Care of the other recipients with whom services are shared.

Transportation

The cost of transportation is included in the rate paid to the provider. There is no mileage limit specified for this service.

Standards

The provider must possess a current, valid Home and Community-Based Service Providers License to provide supervised independent living or personal care attendant services and enroll as a Medicaid waiver provider.

Service Limitations

CID services, including any combination of shared and non-shared CID services, are limited to 60 hours per recipient per Plan of Care year.

To utilize this service, the recipient may or may not be present as identified in the approved Plan of Care.

Reimbursement

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

Residential Habilitation – Supported Independent Living

Residential Habilitation – Supported Independent Living (SIL) services assist recipients, age 18 years of age or older, to acquire, improve, or maintain social and adaptive skills necessary to enable them to reside in the community and to participate as independently as possible.

SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping, money management and bill paying. SIL services may serve to reinforce skills or lessons taught in school, therapy or other settings.

SIL services also assist recipients in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff, and accessing other programs for which he/she qualifies.

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

Place of Service

Services are provided in the recipient's place of residence and/or in the community. The recipient's residence includes his/her apartment or house, not the residence of a legally responsible relative. An exception will be considered when the recipient lives in the residence of a legally responsible relative who is age 70 or older or who is disabled.

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

SIL services cannot be provided in the following settings:

- A Substitute Family Care home or
- A Center-Based Respite facility.

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide supervised independent living services and enroll as a Medicaid waiver provider.

Service Exclusions

Legally responsible relatives may not be SIL providers. Payment for SIL does not include payments made directly or indirectly to the members of the recipient's immediate family.

SIL does not include the cost of the following:

- Meals or the supplies needed for meal preparation,
- Room and board,
- Home maintenance or upkeep and improvement,
- Routine care and supervision which could be expected to be provided by a family member, or
- Activities or supervision for which a payment is made by a source other than Medicaid (e.g. OCDD).

Service Limitations

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

Provider-owned or recipient leased property where services are provided must be compliant with the Americans with Disabilities Act as applicable to the recipient's individual needs.

Recipients must be able to choose to receive supports from any provider on the Freedom of Choice list in their region. When an SIL provider owns or leases property to a recipient, the provider shall not terminate or refuse to renew a recipient's lease based solely on the recipient's choice of utilizing another provider for his/her service delivery. A recipient's lease shall not be tied to a provider's service agreement.

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

The SIL per diem rate will not be paid to an SIL provider agency for recipients in the Self-Direction option, as these recipients are responsible for directing their own care.

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The service unit is one per day per Plan of Care year and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

Substitute Family Care

Substitute Family Care (SFC) is a stand-alone family living arrangement for recipients, age 18 years of age or older, in which the SFC house parents assume the direct responsibility for the recipient's physical, social, and emotional well-being and growth, including family ties.

SFC provides recipients who live in a licensed SFC home with the following:

- Day programming,
- Transportation,
- Independent living training,
- Community integration,
- Homemaker,
- Chore,
- Attendant care and companion services, and
- Medication oversight (to the extent permitted under state law).

The provider is required to develop an Individualized Service Plan (ISP) for the provision of Substitute Family Care services based on the recipient's approved Plan of Care.

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide substitute family care services and enroll as a Medicaid waiver provider.

Service Exclusions

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

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SFC homes shall not be Supported Independent Living settings.

Service Limitations

No more than three recipients, who are unrelated to the SFC provider, are allowed to live in an SFC setting.

SFC services cannot exceed 365 days a year.

Reimbursement

The service unit is one service per day and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information)

Day Habilitation

Day Habilitation services provide recipients, age 18 years or older, with assistance in developing social and adaptive skills necessary to enable them to participate as independently as possible in the community. Day Habilitation services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness.

Day Habilitation services must be directed by a service plan that has been developed by the provider to address the recipient's Plan of Care goals, and to provide assistance and/or training in the performance of tasks related to acquiring, maintaining, or improving skills including but not limited to the following:

- Personal grooming,
- Housekeeping,
- Laundry,
- Cooking,
- Shopping, and
- Money management.

Day Habilitation services must be coordinated with any physical, occupational, or speech therapies, employment-related training or employment listed in the recipient's approved Plan of Care, and may serve to reinforce skills or lessons taught in school, therapy, or other settings to

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attain or maintain the recipient's maximum functional level. The recipient does not receive payment for the activities in which they are engaged.

Some examples of Day Habilitation services include, but are not limited to, the following:

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

Transportation

Transportation provided for the recipient to the site of the day habilitation or between the day habilitation and supported employment model site (if the recipient receives services in more than one place) is reimbursable when day habilitation has been provided.

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The NOW reimburses two separate per diem rates for transportation when Day Habilitation and/or Supported Employment services have been provided to the recipient. One rate covers regular transportation and the other rate covers wheelchair transportation.

Reimbursement may be made for a one-way trip if the reason is documented in the provider's transportation log. There is a maximum fee per day that may be charged for transportation, regardless of the number of trips made per day.

Place of Service

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

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide adult day care services and enroll as a Medicaid waiver provider. Transportation providers must carry at least \$1,000,000 liability insurance on the vehicles used in transporting the recipients.

Service Limitations

The service unit is 15 minutes and is reimbursed at a flat rate. (See Appendix E for Rate and Billing Code information). Day Habilitation services may be provided one or more hours per day, not to exceed eight hours per day or 2,080 hours per recipient per Plan of Care year.

The provider may only bill for transportation for the date(s) which the recipient received Day Habilitation services as indicated in the approved Plan of Care.

Both the recipient and the direct service worker must be present in order for the provider to bill for this service.

Services cannot be provided or billed for during the same hours on the same day as: Supported Employment models; Employment-Related Training; Professional Services; Individual and Family Support – Day/Night/Shared; Community Integration and Development; or Center-Based Respite.

Supported Employment

Supported employment is competitive work, for individuals who are 18 years of age or older, in an integrated work setting, or employment in an integrated work setting in which the individuals

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are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of individuals for whom competitive employment has not traditionally occurred.

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

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

Supported Employment includes activities needed to sustain paid work by recipients, including supervision and training, as specified in the recipient's Plan of Care.

Supported Employment services also includes assistance and prompting with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, other personal care and behavioral support needs and any medical task which can be delegated. Personal care assistance may not comprise the entirety of this service.

Types of Supported Employment Services

Reimbursement for supported employment includes an individualized service plan for each of the following models.

Individual Placement or One-to-One Model

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

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

Follow Along

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

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Mobile Work Crew/Enclave

Mobile Work Crew/Enclave is an employment setting in which a group of two or more recipients, but fewer than eight perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). The recipients may be dispersed throughout the company and among workers, or congregated as a group in one part of the business.

Transportation

Transportation provided for the recipient to the site of the supported employment model, or between the day habilitation and supported employment model site (if the recipient receives services in more than one place) is reimbursable when Supported Employment services have been provided.

The NOW reimburses two separate per diem rates for transportation when Day Habilitation and/or Supported Employment services have been provided to the recipient. One rate covers regular transportation and the other rate covers wheelchair transportation.

Reimbursement may be made for a one-way trip if the reason is documented in the provider's transportation log. There is a maximum fee per day that may be charged for transportation, regardless of the number of trips made per day.

Place of Service

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

Standards

The provider must possess a valid certificate of compliance as a Community Rehabilitation Provider (CRP) from Louisiana Rehabilitation Services or have 15 hours of documented initial and annual vocational-based training.

Transportation providers must possess a current valid Home and Community-Based Service Providers License to provide adult day care services and enroll as a Medicaid waiver provider. The licensed provider must carry at least \$1,000,000 liability insurance on the vehicles used in transporting the recipients.

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Service Exclusions

Supported Employment services cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Employment-Related Training, Professional Services, Individualized and Family Support – Day/Night/Shared, or Center-Based Respite.

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

Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).

Service Limitations

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

Reimbursement

Billing for this service is only allowed when the recipient and direct service worker were both present.

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

NOTE: See Appendix E for Rate and Billing Code information.

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The provider may only bill for transportation for the date(s) which the recipient received Supported Employment services as indicated in the approved Plan of Care.

Employment-Related Training

Employment-Related Training services consists of paid employment for recipients age 18 or older, for whom competitive employment at or above the minimum wage is unlikely, and who need intensive ongoing support to perform in a work setting because of their disability. Services include teaching such concepts as compliance, task completion, problem solving, and safety to address underlying generalized habilitation goals (e.g. attention span, motor skills) that are associated with performing compensated work.

Employment-Related Training services include, but are not limited to:

- Assistance and prompting in the development of employment-related skills. This may include assistance with the following:
 - Personal hygiene,
 - Dressing,
 - Grooming,
 - Eating,
 - Toileting,
 - Ambulation or transfers,
 - Behavioral support needs, and any medical task, which can be delegated.

NOTE: Personal care assistance may not comprise the entirety of this service.

- Employment at a commensurate wage at a provider facility for a set or variable number of hours,
- Observation of an employee of an area business to obtain information to make an informed choice regarding vocational interest,
- Instruction on how to use work-related equipment,
- Instruction on how to observe basic work-related personal safety skills,
- Assistance in planning appropriate meals for lunch while at work,
- Instruction on basic personal finance skills, and

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- Information and counseling to a recipient and, as appropriate, his/her family on benefits planning and assistance in the process.

The recipient may be paid for engaging in this service, according to federal regulations, by the Employment-Related Training provider. If a recipient is paid above 50 percent of the minimum wage, there must be a review every six months to determine the suitability of this service rather than Supported Employment services.

Transportation

The cost of transportation is included in the rate paid to the provider. There is no mileage limit specified for this service.

Standards

Providers must possess a current, valid Home and Community-Based Service Providers License to provide adult day care services and enroll as a Medicaid waiver provider. Providers must also have a valid certificate of compliance as a Community Rehabilitation Provider (CRP) from Louisiana Rehabilitation Services or have 15 hours of documented initial and annual vocational-based training.

Service Exclusions

Services are not available to recipients who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).

Service Limitations

Services must not exceed eight hours a day, five days a week, and cannot exceed 8,320 ¼ hour units of service per Plan of Care year.

Employment-Related Training cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Supported Employment models, Professional Services, Individualized and Family Support – Day/Night/Shared, or Center-Based Respite.

Reimbursement

The service unit is 15 minutes. (See Appendix E for Rate and Billing Code information)

Billing for this service is only allowed when the recipient and direct service worker were both present.

Environmental Accessibility Adaptations

Environmental Accessibility Adaptations are physical modifications to the private residence or vehicle of the recipient or his/her family that are necessary to ensure the health, welfare, and safety of the recipient or that enable the recipient to function with greater independence in the home and/or community, and without these services, the recipient would require additional supports or institutionalization.

Environmental Accessibility Adaptations may include the following:

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

Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the OCDD regional waiver office or Human Services Authority or District.

Standards

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

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

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

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

Service Exclusions

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

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

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

Home modification funds are not intended to cover basic construction cost. For example, in a new facility a bathroom is already part of the building cost, waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation must pay for a specific approved adaptation. Modifications to the home shall meet all applicable state and local building or housing code standards.

Car seats are not considered as a vehicle adaptation.

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

Service Limitations

There is a cap of \$7,000 per recipient for environmental accessibility adaptations. Once a recipient reaches 90 percent or greater of the cap, and the account has been dormant for three years, the recipient may access another \$7,000. Any additional environmental accessibility expenditures during the dormant period will reset the three-year time frame.

Authorization to Exceed Cap

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

Reimbursement

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

A written, itemized, detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted to the OCDD regional waiver office for prior authorization. The support coordinator will assist the recipient in completing the "Environmental Accessibility Adaptation Job Completion Form" (See Appendix

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D for a copy of this form) and any other associated documentation to request prior authorization. The OCDD regional waiver office or Human Services Authority or District must approve the request prior to any work being initiated.

The environmental accessibility adaptation, whether from an original claim, corrected claim, resubmit or revision to the Plan of Care, must be accepted by the recipient, fully delivered, installed, operational, and reimbursed in the current Plan of Care year in which it was approved. Payment will not be authorized until written documentation which demonstrates that the job is completed to the satisfaction of the recipient has been received by the support coordinator.

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

The support coordinators must contact the OCDD regional waiver office before approving modifications for a recipient leaving an ICF/DD.

Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies (SMES) are specified devices, controls, or appliances, which enable recipients to increase their ability to perform the activities of daily living, ensure safety, or perceive, control, and communicate with the environment in which they live.

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

- Sip and puffer switches,
- Specialized switches,
- Voice activated, light activated, or motion activated devices to access the recipient's environment,
- Generators for recipients whose medical condition warrants such an item, such as recipients who require ventilators,
- Items medically necessary for life support, and
- Ancillary supplies and equipment necessary for the proper functioning of

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medically necessary items.

SMES may also be used for routine maintenance or repair of specialized equipment. All items shall meet applicable standards of manufacture, design, and installation. Pictures, brochures, and or other descriptive information must accompany the “Specialized Medical Equipment and Supplies Purchase and Repair Form” and must be approved by the OCDD regional waiver office or the Human Services Authority or District. Prior authorization must be received prior to purchase/maintenance/repair. (See Appendix D for a copy of this form)

Standards

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

All agencies who are vendors of technological equipment and supplies must be enrolled in the Medicaid Program as a Durable Medical Equipment (DME) provider and must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.

Service Exclusions

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

- Appliances (washer, dryer, stove, dishwasher, vacuum cleaner, etc.),
- Daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, Q-tips, etc.),
- Rent subsidy,
- Food, bed covers, pillows, sheets etc.,
- Swimming pools, hot tubs etc.,
- Eye exams,
- Athletic and tennis shoes,
- Automobiles,
- Van lifts for vehicles that do not belong to the recipient or his/her family,

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- Adaptive toys or recreation equipment (swing set, etc.),
- Personal computers and software,
- Exercise equipment,
- Taxi fares, intra and interstate transportation services, and bus passes,
- Pagers, including monthly service,
- Telephones, including mobile telephones and monthly service, and
- Home security systems, including monthly service.

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

Service Limitations

There is a cap of \$1,000 per recipient for specialized medical equipment and supplies. Once a recipient reaches 90 percent or greater of the cap and the account has been dormant for three years, the recipient may access another \$1,000.

Any additional specialized medical equipment and supplies expenditures during this dormant three-year period resets the three-year time frame.

Authorization to Exceed Cap

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

Personal Emergency Response Systems

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

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

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

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

Standards

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

Service Limitations

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

Reimbursement

Reimbursement will be made for a one time installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS. (See Appendix E for Rate and Billing Code information)

Professional Services

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

Professional Services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid State Plan.

Professional Services may be utilized for the following:

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- Performing assessments and/or re-assessments and recommendations,
- Providing consultative services and recommendations,
- Providing training or therapy to an individual and/or their natural and formal supports necessary to either develop critical skills that may be self-managed by the recipient or maintained according to the recipient's needs,
- Intervening in and stabilizing a crisis situation, behavioral or medical that could result in the loss of home and community-based services, or
- Providing necessary information to the recipient, family, caregivers and/or team to assist in the implementation of plans according to the approved Plan of Care.

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

Psychological Services

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

Psychological Services include the following:

- Counseling (a variety of techniques and procedures used by the therapist, e.g., structuring and reinforcement, social modeling, and functional activities)
- Behavior evaluation for the purpose of therapy,
- Intervening and stabilizing a crisis situation,
- Ongoing therapeutic support,
- Ongoing behavior training for staff and/or families,
- Administering and interpreting tests and measurements within the scope of practice of behavior therapy,

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- Administering, evaluating, and modifying treatment and consulting within the scope of practice of behavior therapy,
- Adapting environments specifically for the recipient, and
- Consultative services and recommendations.

Social Work Service

Social Work Service is highly specialized direct counseling furnished by a licensed clinical social worker (LCSW), designed to meet the unique counseling needs of recipients with developmental disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address the recipient's personal outcomes and goals listed in his/her approved Plan of Care.

Nutritional/Dietary Service

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

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

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

Standards

Professionals rendering service(s) must possess a current valid Louisiana license to practice with one year post licensure experience in their field of expertise. The professional may be employed by or contracted with the Personal Care Attendant agency, Supported Independent Living agency, or Home Health agency to provide this service.

Providers must be licensed by the Louisiana Department of Health and Hospitals and enrolled as a waiver service provider of Personal Care Attendant, Supported Independent Living, or Home Health services.

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Agencies enrolled as both Supported Independent Living and Personal Care Attendant provider types shall bill these professional services under their Personal Care Attendant number in accordance with the requirements of the fiscal intermediary. Agencies enrolled as only Supported Independent Living or Home Health providers shall bill under their Supported Independent Living or Home Health provider number.

Service Exclusions

The following activities are not reimbursable:

- Friendly visiting, attending meetings,
- Time spent on paperwork or travel,
- Time spent writing reports and progress notes,
- Time spent on billing of services, and
- Other non-Medicaid reimbursable activities such as time spent on general staff training not related to training for the natural or paid support regarding the recipient's Plan of Care.

Service Limitations

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

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

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

Professional Services cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Transportation for Day Habilitation, Supported Employment models, Transportation for Supported Employment models, Employment-Related Training, Individual and Family Support – Day/Night/Shared, Skilled Nursing Services, or Center-Based Respite.

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

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Reimbursement

The service unit is 15 minutes.

Skilled Nursing

Skilled Nursing is medically necessary nursing services ordered by a physician and provided by a registered nurse or a licensed practical nurse licensed to practice in the state of Louisiana. Skilled Nursing must be provided by a licensed, enrolled home health agency and requires an individual nursing service plan, and must be included in the recipient's approved Plan of Care.

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

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

All Medicaid State Plan services must be utilized before accessing this service. Recipients under the age of 21 must access skilled nursing services as outlined on the Plan of Care through the Home Health Program.

Shared Supports

Skilled Nursing may be shared when there is more than one recipient in the home receiving these services. Payment for shared services must be coordinated with the service authorization system and specified in each recipient's approved Plan of Care.

Standards

The provider must possess a current valid license as a home health agency by the Louisiana Department of Health and Hospitals and be enrolled as a Medicaid waiver provider of Home Health.

Service Exclusions

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

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Service Limitations

Skilled Nursing cannot be provided or billed for during the same hours on the same day as: Transportation for Day Habilitation, Transportation for Supported Employment, Professional Services, Individualized and Family Support – Day/Night/Shared, or Center-Based Respite.

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

Authorization to Exceed 12-Hour Skilled Nursing Service Cap

Requests for 12 hours or less per day of Skilled Nursing may be approved by the OCDD regional waiver office or Human Services Authority or District. All requests received for more than 12 hours per day must be approved by the Department of Health and Hospitals (DHH) Medical Director and Medical Evaluation Team and will be forwarded to the OCDD regional waiver office or Human Services Authority or District by the OCDD Central Office for processing. A request to increase the number of hours per day above the number of hours already approved requires the primary care physician to document the medical change(s) of the recipient necessitating the increase in the request for nursing services.

Reimbursement

The service unit is 15 minutes.

One – Time Transitional Expenses

One – Time Transitional Expenses are non-reoccurring set-up expenses for recipients, age 18 and older, who are transitioning from an Intermediate Care Facility for People with Developmental Disabilities (ICF/DD) to their own home or apartment in the community of their choice.

The recipient's home is defined as the recipient's own residence and does not include the residence of any family member or a substitute family care home.

Allowable transitional expenses include the following:

- The purchase of essential furnishings such as
 - Bedroom and living room furniture,
 - Table and chairs,
 - Window blinds,
 - Eating utensils,
 - Food preparation items, and
 - Bed/bath linens.

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

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

Standards

This service shall only be provided by the Louisiana Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD) with coordination of appropriate entities.

Service Exclusions

The following expenses are not covered under One-Time Transitional Services:

- Payments for housing or rent,
- Payments for regular utility charges,
- Household appliances/items that are intended for purely divisional/recreational purposes,
- Refundable security deposits,
- Food purchases, and
- Payment of furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Service Limitations

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

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Housing Stabilization Transition Service and Housing Stabilization Service

The following housing support services assist waiver recipients to obtain and maintain successful tenancy in Louisiana's Permanent Supportive Housing (PSH) Program.

Housing Stabilization Transition Service

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

- Conducting a housing assessment that identifies the recipient's preferences related to housing (type and location of housing, living alone or living with someone else, accommodations needed, and other important preferences), and identifying the recipient's needs for support to maintain housing, including:
 - Access to housing,
 - Meeting the terms of a lease,
 - Eviction prevention,
 - Budgeting for housing/living expenses,
 - Obtaining/accessing sources of income necessary for rent,
 - Home management,
 - Establishing credit, and
 - Understanding and meeting the obligations of tenancy as defined in the lease terms.
- Assisting the recipient to view and secure housing as needed. This may include:
 - Arranging or providing transportation,
 - Assisting in securing supporting documents/records,
 - Assisting in completing/submitted applications,
 - Assisting in securing deposits, and
 - Assisting in locating furnishings.
- Developing an individualized housing support plan based upon the housing assessment that:
 - Includes short and long-term measurable goals for each issue,
 - Establishes the recipient's approach to meeting the goal(s), and
 - Identifies where other provider(s) or services may be required to meet the

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goal(s).

- Participating in the development of the Plan of Care and incorporating elements of the housing support plan, and
- Exploring alternatives to housing if permanent supportive housing is unavailable to support completion of the transition.

Housing Stabilization Service

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

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

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the scope of housing stabilization service, the needs must be communicated to the support coordinator.

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

Standards

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

Service Exclusions

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

Service Limitations

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

Reimbursement

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

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Payment will not be authorized until the final Plan of Care approval is received.

The OCDD regional waiver office reviews all documents to ensure all requirements are met. If all requirements are met, the support coordinator provides a copy of the approved Plan of Care to the recipient and the permanent supportive housing provider. The permanent supportive housing provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

Services must be billed in 15 minute units.

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SECTION 32.2: SELF-DIRECTION OPTION**PAGE(S) 1**

SELF-DIRECTION OPTION

Self-direction is a service delivery option which allows recipients to become the employer of the direct service workers they choose to hire to provide their supports. As the employer, the recipient or his/her authorized representative is responsible for recruiting, training, supervising and managing their direct service workers.

A required component of this option is the use of a contracted fiscal/employer agent who will perform the recipient's employer-related payroll functions. Recipients must utilize support coordination services for the development of the Plan of Care, budget planning, ongoing evaluation of supports and services and for organizing the unique resources the recipient needs.

Recipients participating in this option must:

- Be a NOW recipient,
- Be able to participate in this option without a lapse or decline in quality of care or an increased risk to his/her health and welfare,
- Complete the mandatory training including rights and responsibilities of managing his/her own services and supports offered by the support coordinator, and
- Understand the rights, risks, and responsibilities of managing his/her own care, and managing and using an individual budget, or if unable to make decisions independently, have a willing decision maker (authorized representative who is listed on the recipient's plan of care) who understands the rights, risks, and responsibilities of managing the care and supports of the recipient within the individualized budget.

NOTE: An individual who is able to make decisions independently or who have an authorized representative as their willing decision maker is not eligible to enroll in the Self-Direction option and also receive or continue to receive Supervised Independent Living services.

RECIPIENT REQUIREMENTS

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

- Meet the Developmental Disability Law criteria as defined in Appendix A,
- Have his/her name on the Developmental Disabilities Request for Services Registry (RFSR) for the New Opportunities Waiver (NOW),
- Meet the financial and non-financial Medicaid eligibility criteria for Medicaid services,
- Meet the medical requirements,
- Meet the requirements for an Intermediate Care Facility for people with a Developmental Disability (ICF/DD) level of care which requires active treatment of mental retardation or a developmental disability under the supervision of a qualified mental retardation or developmental disability professional,
- Meet the health and welfare assurance requirements for home and community based waiver services, and
- Be a resident of Louisiana.

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

Request for Services Registry

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots. Individuals who request waiver services are placed on a statewide Developmental Disabilities Request for Services Registry (RFSR) and are selected for a waiver opportunity in the date order in which they applied. Exceptions include people who qualify for the NOW program through emergency placements or other designated placements.

Requests for waiver services must be made from the applicant or his/her authorized representative by contacting the applicant's local Office for Citizens with Developmental Disabilities (OCDD) regional office or Human Services Authority or District.

Once it has been determined by the OCDD regional office or Human Services Authority or District that the applicant meets the definition of a developmental disability as defined by the

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SECTION 32.3: RECIPIENT REQUIREMENTS**PAGE(S) 4**

Louisiana Developmental Disability Law (See Appendix A), the applicant's name will be placed on the RFSR in request date order and the applicant/authorized representative will be sent a letter stating the individual's name has been secured on the RFSR along with the original request date. Entry into the NOW will be offered to applicants from the RFSR by date/time order of the earliest request for services.

Inactive Status

An applicant may choose to be placed in an inactive status on the RFSR by notifying the OCDD regional office or Human Services Authority or District. When the applicant determines that he/she is ready to begin the NOW evaluation process, he/she must request in writing to the OCDD regional office or Human Services Authority or District that his/her name be removed from inactive status. The applicant's original request date will be reinstated and he/she will be notified when the next NOW opportunity becomes available.

Verifying Request Date

Applicants or their authorized representatives may verify their request date by calling their local OCDD regional office or Human Services Authority or District.

Level of Care

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

The BHSF "Request for Medical Eligibility Determination" 90-L Form is the instrument used to determine if an applicant meets the level of care of an ICF/DD. The 90-L Form must be completed, signed, and dated by the individual's Louisiana licensed primary care physician. The 90-L Form must be submitted with the individual's initial or annual Plan of Care to the OCDD regional waiver office. The OCDD regional waiver office is responsible for determining that the required level of care is met for each recipient.

The applicants/authorized representatives are ultimately responsible for obtaining the completed 90-L Form from the applicant's primary care physician. This form must be obtained prior to linkage to a support coordination agency for an initial Plan of Care and no more than 90 days before the annual Plan of Care start date.

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

Discharge Criteria

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

- Loss of Medicaid financial eligibility as determined by the parish Medicaid Office,
- Loss of eligibility for an ICF/DD level of care as determined by the OCDD regional waiver office or Human Services Authority or District,
- Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities,
- Change of residence to another state with the intent to become a resident of that state,
- Admission to an ICF/DD or nursing facility with the intent to stay and not return to waiver services. The waiver recipient may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The recipient will be discharged from the waiver on the 91st day if the recipient is still in the facility. Payment for waiver services will not be authorized when the recipient is in a facility.
- Unable to assure the health and welfare of the recipient in the community through the provision of reasonable amounts of waiver services as determined by the OCDD regional office, i.e., the recipient presents a danger to himself/herself or others,
- Failure to cooperate in either the eligibility determination process or the initial or annual implementation of the Plan of Care, or fulfilling his/her responsibilities as a NOW recipient,
- Interruption of services as a result of the recipient not receiving and/or refusing NOW services (exclusive of support coordination services) during a period of 30 or more consecutive days. This does not include interruptions in NOW services because of hospitalization, institutionalization (such as ICF/DD or nursing facilities) or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. This interruption cannot exceed 90 days and there is a documented expectation from the treating physician that the individual will return to the NOW services. During this 90-day period, OCDD will not authorize payment for NOW services or,

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SECTION 32.3: RECIPIENT REQUIREMENTS

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

RIGHTS AND RESPONSIBILITIES

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

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

Freedom of Choice of Program

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

Notification of Changes

Support coordinators and service providers may not approve or deny eligibility for the waiver or approve services in the waiver program.

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

The DHH - Office for Citizens with Developmental Disabilities (OCDD) is responsible for approving level of care and medical certification per the Plan of Care. In order to maintain this certification, recipients have the responsibility to inform OCDD through their support coordinator of any significant changes which will affect their service needs.

Participation in Care

Support coordinators and service providers shall allow recipients/authorized representatives to participate in all person-centered planning meetings and any other meeting concerning their services and supports. Person-centered planning will be utilized in developing all services and supports to meet the recipient's needs. By taking an active part in planning his/her services, the recipient is better able to utilize the available supports and services.

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SECTION 32.4: RIGHTS AND RESPONSIBILITIES**PAGE(S) 3**

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

The support coordinator must request changes in the amount of services at least seven days before taking effect, except in emergencies. Service providers may not initiate requests for change of service or modify the Plan of Care without the participation and consent of the recipient.

Freedom of Choice of Support Coordination and Service Providers

Support coordinators should be aware that at the time of admission to the waiver and every six months thereafter, recipients have the opportunity to change providers, if one is available. Recipients may request a change by contacting the OCDD regional waiver office or Human Services Authority or District.

Support coordinators will provide recipients with their choice of direct service providers and help arrange for the services included in the Plan of Care. Recipients have the opportunity to choose service providers initially and every six months thereafter unless a change is requested for good cause.

Voluntary Participation

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

Compliance with Civil Rights

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

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SECTION 32.4: RIGHTS AND RESPONSIBILITIES

Quality of Care

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

Grievances/Fair Hearings

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

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

Rights and Responsibilities Form

A complete list of the recipient's rights and responsibilities is included in Appendix D. The support coordinator must review these rights and responsibilities with the recipient and his/her authorized representative as part of the initial intake process into waiver services.

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SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for an additional New Opportunities Waiver (NOW) opportunity or an existing opportunity is vacated, the next individual on the Request for Services Registry (RFSR) will receive a written notice indicating that a waiver opportunity is available. That individual will be evaluated for a possible NOW assignment.

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

Prior to linkage to a support coordination agency, the applicant must have provided the Medicaid data contractor with a current 90-L form that has been completed, signed and dated by his/her Louisiana licensed primary care physician. Once linked, the support coordinator will assist the applicant in gathering the documents which may be needed for both the financial eligibility and medical certification process for level of care determination. The support coordinator informs the individual of the freedom of choice of enrolled waiver providers and the availability of services as well as the assistance provided through the support coordination service.

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

- The applicant's assessed needs,
- The types and number of services (including waiver and all other services) necessary to maintain the applicant safely in the community,
- The individual cost of each service (including waiver and all other services), and
- The average cost of services per day covered by the Plan of Care.

Provider Selection

The support coordinator must present the recipient with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the Plan of Care. The support coordinator will have the recipient or responsible representative complete the provider Freedom of Choice (FOC) form initially and annually thereafter for each identified waiver service.

The support coordinator is responsible for:

- Notifying the provider that the recipient has selected their agency to provide the

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necessary service.

- Requesting the provider sign and return the following:
 - Section IX of the Plan of Care and/or the individual support plan,
 - Emergency Plan, and
 - Individualized Staffing Back-up Plan.
- Forwarding the Plan of Care packet to the Office for Citizens with Developmental Disabilities (OCDD) regional waiver office or Human Services Authority or District for review and approval.

NOTE: The authorization to provide service is contingent upon approval by the OCDD regional waiver office or Human Services Authority or District.

Prior Authorization

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

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

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

The service provider is responsible for the following activities:

- Checking prior authorizations to verify that all prior authorizations for services match the approved services in the recipient's Plan of Care. Any mistakes must be immediately corrected to match the approved services in the Plan of Care.
- Verifying that the direct service worker's timesheet is completed correctly and that services were delivered according to the recipient's approved Plan of Care prior to billing for the service.

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- Verifying that services were documented as evidenced by timesheets and progress notes and are within the approved service limits as identified in the recipient's Plan of Care prior to billing for the service.
- Completing data entry into the direct service provider data system, Louisiana Services Tracking (LAST) system.
- Inputting the correct date(s) of service, authorization numbers, provider number, and recipient number in the billing system.
- Billing only for the services that were delivered to the recipient and are approved in the recipient's Plan of Care.
- Reconciling all remittance advices issued by the DHH fiscal intermediary with each payment.
- Checking billing records to ensure that the appropriate payment was received. (Note: Service providers have a one-year timely filing billing requirement under Medicaid regulations.)

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

NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances.

Post Authorization

To receive post authorization, a service provider must enter the required information into the billing system maintained by the Medicaid data contractor. The Medicaid data contractor checks the information entered into the billing system by the service provider against the prior authorized unit of service. Once post authorization is granted, the service provider may bill the DHH fiscal intermediary for the appropriate units of service.

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

One Time Transitional Expenses

The support coordinator must develop a plan to include the transition expenses for individuals who are moving from an Intermediate Care Facility for people with Developmental Disabilities

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(ICF/DD) into their own residence in the community. No funds will be disbursed without prior authorization of expenditures. The following procedure must be followed to access these funds:

- The support coordinator must complete the “Transitional Expenses Planning and Approval (TEPA) Request Form,” with input from the recipient and his/her circle of support, to document the need for transitional expenses, identify the designated purchaser, and estimate the cost of the items or services that are needed. The recipient may choose to be the designated purchaser or may select his/her authorized representative, support coordinator, or provider to act as the designated purchaser. (See Appendix D for a copy of this form)
- The support coordinator must request pre-approval from the OCDD regional waiver office or Human Services Authority or District by submitting the TEPA request form and the Plan of Care packet, including the Plan of Care budget sheet identifying the estimated TEPA cost, procedure code, provider and provider number, at least 10 working days prior to the recipient’s actual move date.
- The OCDD regional waiver office or Human Services Authority or District sends the completed pre-142 approval letter and pre-approved TEPA request form to the support coordinator and OCDD Central Office Fiscal Section. A copy of the pre-142 approval letter will also be sent to the Medicaid parish office. The purchasing process cannot begin until the pre-142 approval letter is issued to the support coordinator.
- The support coordinator assists the designated purchaser with obtaining the items on the pre-approved TEPA request form.
- After purchases are made, the support coordinator is responsible for:
 - Obtaining the original receipts from the designated purchaser,
 - Identifying the pre-approved items to be reimbursed,
 - Notating the actual cost of the pre-approved items on the TEPA request form,
 - Summarizing all items purchased by the designated purchaser on the “NOW TEPA Invoice Form,”
 - Completing the “Request for Taxpayer Identification Number and Certification” (W-9 form) if the designated purchaser is not established as a state vendor, and
 - Informing the designated purchaser of the timeframes and procedures to be followed in order to obtain reimbursement.
- The support coordinator must submit the pre-approved TEPA request form,

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original receipts, W-9 form (if applicable), and the TEPA Invoice form to the OCDD regional waiver office or Human Services Authority or District at least 10 working days following the pre-certification home visit.

- The OCDD regional waiver office or Human Services Authority or District reviews the purchased items with the recipient/authorized representative at the pre-certification home visit for approval.
- The OCDD regional waiver office or Human Services Authority or District mails the 18-W form, original receipts, pre-approved TEPA request form, and NOW TEPA Invoice Form to the OCDD Central Office Fiscal Section upon receipt. Payment will not be authorized until the OCDD regional waiver office or Human Services Authority or District gives final Plan of Care approval upon receipt of the 18-W form.
- The OCDD Central Office Fiscal Section establishes a transition expense record for the recipient and utilizes the pre-approved TEPA request form to ensure that only the item/services listed are reimbursed to the designated purchaser.
- The support coordinator must submit to the OCDD regional waiver office or Human Services Authority or District a revised Plan of Care budget sheet if there are any cost differences between the approved estimated TEPA cost and the actual TEPA cost.
- The OCDD Central Office Fiscal Section sends the “OCDD Verification of Actual TEPA Costs” form to the OCDD regional waiver office or Human Services Authority or District for service authorization.
- The OCDD regional waiver office or Human Services Authority or District gives final approval on the “OCDD Verification of Actual TEPA Costs” form and faxes it to the Medicaid data contractor along with the approved TEPA request form and accompanying Plan of Care budget sheets. A copy of the “OCDD Verification of Actual TEPA Costs” form is faxed back to the OCDD Central Office Fiscal Section for documentation in the OCDD payment record.
- Service authorization is issued to the OCDD Central Office Fiscal Section for the actual cost of items as identified on the approved TEPA request form. Any new items not on the original approved TEPA Request Form will not be reimbursed.
- The OCDD Central Office forwards the reimbursements to the designated purchaser upon payment from Medicaid.

All billing must be completed by the Plan of Care end date in order for the reimbursement to be

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paid. OCDD central office Fiscal Section maintains documentation for accounting and monitoring purposes of each recipient's TEPA request including original receipts and record of payments to the designated purchaser

Additional requests for One Time Transitional Expenses must be requested by the recipient and submitted by the support coordinator on a new TEPA request form to the OCDD regional waiver office or Human Services Authority or District following the above procedure. Requests may be submitted up to 30 calendar days after the stamped receipt date of the 18-W in the OCDD regional waiver office or Human Services Authority or District.

Changes

All requests for changes in services and/or service hours must be made by the recipient or his/her personal representative.

Changing Direct Service Providers

Recipients may change direct service providers once every service authorization quarter (three months) with the effective date being the beginning of the following quarter. Direct service providers may be changed for good cause at any time as approved by the OCDD regional waiver office or Human Services Authority or District.

Good cause is defined as:

- A recipient moving to another region in the state where the current direct service provider does not provide services,
- The recipient and the direct service provider have unresolved difficulties and mutually agree to a transfer,
- The recipient would like to share supports with another recipient who has a different provider agency, regardless of the recipients' relationship,
- The recipient's health, safety or welfare have been compromised, or
- The direct service provider has not rendered services in a manner satisfactory to the recipient or his/her authorized representative.

Recipients and/or their authorized representative must contact their support coordinator to change direct service providers.

The support coordinator will assist in facilitating a support team meeting to address the recipient's reason for wanting to terminate services with the current service provider(s).

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Whenever possible, the current service provider should have the opportunity to submit a corrective action plan with specific timelines, not to exceed 30 days, to attempt to meet the needs of the recipient.

If the recipient/authorized representative refuses a team meeting, the support coordinator and OCDD regional waiver office or Human Services Authority or District determines that a meeting is not possible or appropriate, or the corrective action plan and timelines are not met, the support coordinator will:

- Provide the recipient/ authorized representative with a current FOC list of service providers in his/her region.
- Assist the recipient/authorized representative in completing the FOC list and release of information form,
- Ensure the current provider agency is notified immediately upon knowledge and prior to the transfer, and
- Obtain the case record from the releasing provider which must include:
 - Progress notes from the last two months, or if the recipient has received services from the provider for less than two months, all progress notes from date of admission,
 - Written documentation of services provided, including monthly and quarterly progress summaries,
 - Current Individualized Service Plan (ISP),
 - Records tracking recipient's progress towards ISP goals and objectives, including standardized vocational assessments and/or notes regarding community or facility-based work assessments, if applicable,
 - Records of job assessment, discovery, and development activities which occurred, and a stated goal and objective in the most current ISP for the recipient to obtain competitive work in the community, if stated,
 - Copies of current and past behavior management plans, if applicable,
 - Documentation of the amount of authorized services remaining in the Plan of Care, including applicable time sheets, and

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- Documentation of exit interview.

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

- Most current plan of care,
- Current assessments on which the plan of care is based,
- Number of services used in the calendar year,
- Records from the previous service provider, and
- All other waiver documents necessary for the new service provider to begin providing service.

Transfers must be made seven days prior to the end of the service authorization quarter in order to coordinate services and billing, unless the OCDD regional waiver office or Human Services Authority or District waives this requirement in writing due to good cause.

The new service provider must bear the cost of copying, which cannot exceed the community's competitive copying rate.

Prior Authorization for New Service Providers

A new PA number will be issued to the new provider with an effective starting date of the first day of the new quarter or the first day of the first full calendar month following a good cause change. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider.

Neither OCDD nor its agent will backdate the new PA period to the first day of the first full calendar month in which the FOC and transfer of records are completed. If the new provider receives the records and admits a recipient in the middle of a month, the new provider cannot bill for services until the first day of the next month. New providers who provide services prior to the begin date of the new PA period will not be reimbursed.

Exceptions to the existing service provider end date and the new service provider begin date may be approved by the OCDD regional waiver office or Human Services Authority or District when the reason for change is due to good cause as specified above.

Changing Supported Independent Living Providers

Changes in Supported Independent Living (SIL) providers will be effective on the Sunday following the approved request to change agencies. The agency the recipient is leaving will be

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responsible for completing all three required contacts in the last week. The new provider agency will be responsible for completing these requirements beginning the week the transfer is effective. In instances where there is a need for an emergency change in providers at any other day during the week, the new provider agency will be responsible for meeting the weekly requirements.

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

Changing Support Coordination Agencies

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

- A recipient moving to another region in the state,
- The recipient and the support coordination provider have unresolved difficulties and mutually agree to a transfer,
- The recipient's health, safety or welfare have been compromised, or
- The support coordination provider has not rendered services in a manner satisfactory to the recipient.

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

PROVIDER REQUIREMENTS

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

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

Providers must attend all mandated meetings and training sessions as directed by the Office for Citizens with Developmental Disabilities (OCDD) as a condition of enrollment and continued participation as a waiver provider. Attendance at a provider enrollment orientation is required prior to enrollment as a Medicaid provider. A Provider Enrollment Packet must be completed for each DHH administrative region in which the agency will provide services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number.

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

Providers must have the necessary computer equipment and software available to participate in prior authorization and data collection.

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

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

Providers must develop a Quality Improvement and Self-Assessment Plan. This is a document completed by the provider describing the procedures that are used, and the evidence that is presented, to demonstrate compliance with program requirements. The first Self-Assessment is due six months after approval of the Quality Improvement Plan and yearly thereafter. The

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Quality Improvement Plan must be submitted for approval within 60 days after the training is provided by DHH.

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

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

Changes in the following areas are to be reported to the Bureau of Health Services Financing Health Standards Section, OCDD and the fiscal intermediary's Provider Enrollment Section in writing at least 10 days prior to any change:

- Ownership,
- Physical location,
- Mailing address,
- Telephone number, and
- Account information affecting electronic funds transfer (EFT).

The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving recipients. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving recipients until the re-certification process is complete.

Waiver services are to be provided only to persons who are waiver recipients, and strictly in accordance with the provisions of the approved Plan of Care.

Providers may not refuse to serve any waiver recipient that chooses their agency unless there is documentation to support an inability to meet the individual's health, safety and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. Such refusal to serve an individual must be put in writing by the provider, and include a detailed explanation as to why the provider is unable to serve the individual. Written notification must be submitted to the OCDD regional waiver office or the Human Service Authority or District. Providers who contract with other entities to provide waiver services must maintain copies of such contracts signed by both agencies. Such contracts must state that the

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subcontractor may not refuse to serve any waiver recipient referred to them by the enrolled direct service provider agency.

The recipient’s provider and support coordination agency must have a written working agreement that includes the following:

- Written notification of the time frames for Plan of Care planning meetings,
- Timely notification of meeting dates and times to allow for provider participation,
- Information on how the agency is notified when there is a Plan of Care or service delivery change, and
- Assurance that the appropriate provider representative is present at planning meetings as invited by the recipient.

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

| Waiver Service | Requirements | Service Provided by |
|---|---|---------------------|
| Individualized and Family Support | Home and Community-Based Services Provider License (Personal Care Attendant Module) | Enrolled agency |
| Center Based Respite | Home and Community-Based Services Provider License (Respite Care Module) | Enrolled agency |
| Community Integration Development | Home and Community-Based Services Provider License (Personal Care Attendant or Supervised Independent Living Module) | Enrolled agency |
| Residential Habilitation – Supported Independent Living | Home and Community-Based Services Provider License (Supervised Independent Living Module) | Enrolled agency |
| Substitute Family Care | Home and Community-Based Services Provider License (Substitute Family Care Module and approved by OCDD) | Enrolled agency |
| Day Habilitation | Home and Community-Based Services Provider License (Adult Day Care Module) | Enrolled agency |
| Supported Employment | Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or 15 hours of documented initial and annual vocational-based training, and to provide transportation a Home and Community-Based Services Provider License (Adult Day Care Center Module) | Enrolled agency |

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| Waiver Service | Requirements | Service Provided by |
|--|---|---|
| Employment-Related Training | Valid Certificate of Compliance as a Community Rehabilitation Provider from Louisiana Rehabilitation Services or 15 hours of documented initial and annual vocational-based training, and to provide transportation a Home and Community-Based Services Provider License (Adult Day Care Center Module) | Enrolled agency |
| Environmental Accessibility Adaptations | Registered through the Louisiana State Licensing Board for Contractors as a Home Improvement Contractor. | Enrolled agency |
| | Vehicle Lifts: Licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category. | |
| Specialized Medical Equipment and Supplies | Must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies. | Enrolled agency |
| Personal Emergency Response Systems | Must meet all applicable vendor requirements, federal, state, parish and local laws for installation. | Enrolled agency |
| Professional Services | Current valid Louisiana license to practice in the field of expertise | Employed or contracted by Personal Care Attendant agency, Supported Independent Living agency or Home Health agency |
| Skilled Nursing | Home Health license | Enrolled agency |
| One Time Transitional Expenses | | OCDD |

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

Other Provider Responsibilities

Providers of NOW services are responsible for the following:

- Ensuring an appropriate representative from the agency attends the Plan of Care planning meeting and is an active participant in the team meeting,

NOTE: An appropriate representative is considered to be someone who has knowledge and authority to make decisions about the recipient’s service delivery.

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This person may be a program manager, a direct service professional who works with or will work with the recipient, the executive director or designee.

- Communicating and working with support coordinators and other support team members to achieve the recipient's personal outcomes,
- Ensuring the recipient's emergency contact information and list of medications are kept current,
- Informing the support coordinator by telephone or e-mail as soon as the agency recognizes that any goals, objectives or timelines in the Plan of Care will not meet the recipient's needs, but not later than 10 days prior to the expiration of any timelines in the service plan that cannot be met,
- Ensuring the provider agency support team member(s) sign and date any revisions to the service plan indicating agreement with the changes to the goals, objectives or time lines,
- Providing the support coordination agency or DHH representatives with requested written documentation including, but not limited to:
 - Completed, signed and dated service plan,
 - Service logs, progress notes, and progress summaries,
 - Direct service worker attendance and payroll records,
 - Written grievance or complaint filed by recipient/family,
 - Critical or other incident reports involving the recipient, and
 - Entrance and exit interview documentation.
- Explaining to the recipient/family in his/her native language the recipient rights and responsibilities within the agency, and
- Assuring that recipients are free to make a choice of providers without undue influence.

Support Coordination Providers

Providers of support coordination for the NOW program must have a signed performance agreement with OCDD to provide services to waiver recipients. Support coordination agencies must meet all of the performance agreement requirements in addition to any additional criteria outlined in the Case Management Services manual chapter.

Direct Service Provider Responsibilities

Direct service provider agencies must have written policy and procedure manuals that include but are not limited to the following:

- Training policy that includes orientation and staff training requirements according to the Personal Care Attendant Licensing Standards and the Direct Service Worker Registry,
- Direct care abilities, skills and knowledge requirements that employees must possess to adequately perform care and assistance as required by waiver recipients,
- Employment and personnel job descriptions, hiring practices including a policy against discrimination, employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances, staffing and staff coverage plan,
- Record maintenance, security, supervision, confidentiality, organization, transfer, and disposal,
- Identification, notification and protection of recipient's rights both verbally and in writing in a language the recipient/family is able to understand,
- Written grievance procedures, and
- Information about abuse and neglect as defined by DHH regulations and state and federal laws.

Individualized Service Plan

The direct service provider must develop an individualized service plan to include all waiver services that the agency provides to the recipient based on the recipient's identified Plan of Care goals.

The individualized service plan must be person-centered, focus on the recipient's desired outcomes, and include the following elements:

- Specific goals matching the goals outlined in the recipient's approved Plan of Care,

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- Measurable objectives and timelines to meet the specified goals,
- Strategies to meet the objectives,
- Identification of the direct service provider staff and any other support team members who will be involved in implementing the strategies, and
- The method that will be used to document and measure the implementation of specified goals and objectives.

The individualized service plan must be reviewed and updated as necessary to comply with the specified goals, objectives, and timelines stated in the recipient's approved Plan of Care.

Back-up Planning

Direct service providers are responsible for providing all necessary staff to fulfill the health and welfare needs of the recipient when paid supports are scheduled to be provided. This includes times when the scheduled direct service worker is absent or unavailable or unable to work for any reason.

All direct service providers are required to develop a functional individualized back-up plan for each recipient that includes detailed strategies and person-specific information that addresses the specialized care and supports needed by the recipient. Direct service providers are required to have policies in place which outline the protocols the agency has established to assure that back-up direct service workers are readily available, lines of communication and chain of command procedures have been established, and procedures for dissemination of the back-up plan information to recipients, their authorized representatives and support coordinators. Protocols must also describe how and when the direct support staff will be trained in the care needed by the recipient. This training must occur prior to any direct support staff being solely responsible for a recipient.

Back-up plans must be updated at least annually to assure that the information is kept current and applicable to the recipient's needs. The back-up plan must be submitted to the recipient's support coordinator in a timely manner to be included as a component of the recipient's initial and annual Plan of Care.

Direct service providers may not use the recipient's informal support system as a means of meeting the agency's individualized back-up plan and/or emergency evacuation response plan requirements. The recipient's family members and others identified in the recipient's circle of support may elect to provide backup, but this does not exempt the provider from the requirement of providing the necessary staff for backup purposes.

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Emergency Evacuation Planning

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

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

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

Training for direct service workers must occur prior to the worker being solely responsible for the support of the recipient.

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

OCDD, support coordination agencies, and direct service provider agencies are responsible for following the established emergency protocol before, during, and after hurricanes as outlined in the "Emergency Protocol for Tracking Location Before, During, and After Hurricanes"

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document found in the OCDD *Guidelines for Support Planning* manual. (See Appendix D for *Guidelines for Support Planning* information)

Residential Habilitation – Supported Independent Living Provider Responsibilities

In addition to the approved direct support hours provided to the recipient, the Supported Independent Living (SIL) provider is responsible for three documented recipient contacts per week. At least one contact must be face-to-face with the recipient, and the other two contacts may be made by telephone. Providers may make as many contacts in a day as are necessary to meet the needs of the recipient; however, only one of those contacts will be accepted as having met one of the three required contacts.

No combination of telephone contacts and the face-to-face contact can be billed or accepted as having met more than one of the required contacts on the same date. Attempted face-to-face contacts or telephone contacts are unacceptable and will not count towards meeting the requirements. Any identified payment made to a provider agency for an incomplete contact will be subject to recoupment of funds paid.

Recipient contacts must be completed by a supervisor of the provider agency or an employee of the provider agency who is a licensed/certified professional qualified in the State of Louisiana and who meets the requirements as defined by the Title 42, Section 483.430 of the Code of Federal Regulations. Providers are required to maintain appropriate documentation indicating these requirements for all required contacts.

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

The provider must provide back-up staff that is available on a 24-hours basis.

SIL services must be coordinated with any services listed in the approved Plan of Care.

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

Day Habilitation Provider Responsibilities

The service provider must possess a current valid Home and Community-Based Service Providers License to provide adult day care services and adhere to the following requirements in order to provide transportation to recipients:

- The provider's vehicles used in transporting recipients must:

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- Be in good repair,
 - Have a current Louisiana inspection sticker,
 - Have a first aid kit on board, and
 - Carry at least \$1,000,000 liability insurance.
- Drivers must have a current Louisiana driver's license applicable to the vehicle being used, and
 - The provider must document this service in the recipient's record and the trip must be documented in the provider's transportation log.

Supported Employment Provider Responsibilities

Supported Employment providers must maintain documentation in the file of each individual recipient that the services are not available to the recipient in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1401 (16) and (71).

The service provider must possess a current valid Home and Community-Based Service Providers License to provide adult day care services and adhere to the following requirements in order to provide transportation to recipients:

- The provider's vehicles used in transporting recipients must:
 - Be in good repair,
 - Have a current Louisiana inspection sticker, and
 - Have a first aid kit on board, and
 - Carry at least \$1,000,000 liability insurance.
- Drivers must have a current Louisiana driver's license applicable to the vehicle being used.
- The provider must document this service in the recipient's record and the trip must be documented in the provider's transportation log.

Employment Related Training Provider Responsibilities

The provider must maintain documentation in the file of each individual recipient receiving Employment-Related Training that the services are not available to eligible recipients in

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programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Individuals with Disabilities Education Act (IDEA) 20 U.S.C. 1401 (16) and (71).

Professional Services – Psychological Provider Responsibilities

Providers of psychological services must:

- Perform an initial evaluation to assess the recipient’s need for services,
- Develop an Individualized Service Plan for the provision of psychological services, which must document the supports that will be provided to the recipient to meet his/her goals based on the recipient’s approved Plan of Care,
- Implement the recipient’s therapy service plan in accordance with appropriate licensing and certification standards,
- Complete progress notes for each session, within ten days of the session, and provide notes to the recipient’s support coordinator every three months or as specified in the Plan of Care,
- Maintain both current and past records and make them available upon request to OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or legislative auditors, and
- Bill only for services rendered, based on the recipient’s approved Plan of Care and prior authorization.

Skilled Nursing Services Provider Responsibilities

Provider agencies of Skilled Nursing services must:

- Ensure that all nurses employed to provide Skilled Nursing services are either registered nurses or licensed practical nurses who have a current Louisiana Board of Nursing license with a minimum of one year of supervised nursing experience in providing Skilled Nursing services in a community setting to recipients.
- Provide an orientation on waiver services to licensed nurses and assure that licensed nurses adhere to the OCDD Critical Incident Reporting policy. (See Appendix D for information regarding this policy)

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- Collect and submit the following documents to the recipient's support coordination agency:
 - Primary care physician's order for Skilled Nursing services.

The physician's order must be signed, dated, and contain the number of hours per day and duration of Skilled Nursing services required to meet the recipient's needs. This order must be updated at least every 60 days. A copy of the physician's order must be sent to the support coordination agency prior to expiration of the previous approval to ensure continuation of services. The physician's order must be submitted to the OCDD regional waiver office with the recipient's annual Plan of Care. Prior authorization will not be released if the physician's order is not submitted as required.
 - Primary care physician's letter of necessity for Skilled Nursing services.

The physician's letter of necessity must be on the physician's letterhead, identify all nursing duties to be performed by the nurse, and state the recipient's current medical condition and need for Skilled Nursing services.
 - Current Form 90-L signed by the recipient's primary care physician.
 - Summary of the recipient's medical history.

The summary must indicate the recipient's service needs, based on a documented record review and specify any recent (within one year) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) extended home health approvals.
 - CMS Form 485 completed by the home health agency to identify the Skilled Nursing service needs.
- Develop and implement an Individual Nursing Service Plan in conjunction with the recipient's physician, support team, and the support coordinator to identify and fulfill the recipient's specific needs in a cost-effective manner.
- Render services to the recipient as ordered by the recipient's primary care physician and as reflected in the recipient's Plan of Care within the requirements of the Louisiana Nurse Practice Act. For the purpose of this policy, nursing assessments, nursing care planning, and revisions of care planning must be

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consistent with the Outcome and Assessment Information Set (OASIS) requirements used by home health agencies that provide Skilled Nursing services.

- Complete progress notes for each treatment, assessment, intervention, and critical incident.
- Provide the support coordination agency with physician-ordered changes every 60 days regarding the recipient's health status and health needs.
- Inform the support coordinator immediately of the providers' inability to provide staff according to the recipient's nursing service plan.
- Report any recipient's non-compliance with or refusal of the established Individual Nursing Service Plan, and provide these notes to the designated support coordinator every three months, or as specified in the Plan of Care.
- Maintain both current and past records and make them available upon request to the OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or legislative auditors.
- Bill for prior authorized services rendered based on the recipient's approved Plan of Care.
- Ensure the home health nurse and the recipient's support coordinator communicate at least monthly to determine if any further planning is required.
- Report any changes in the recipient's nursing service needs to the support coordinator. If necessary, the support coordinator will call an Interdisciplinary Team meeting to review the Plan of Care and to discuss any needed revisions. Changes which increase Skilled Nursing services in accordance with regulations, must revise the Individual Nursing Services Plan every 60 days.

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

- Changes in the Individual Nursing Service Plan must be approved by the primary care physician and reflect the physician's orders for the Skilled Nursing service.
- Ensure the Individual Nursing Service Plan is current and available in the recipient's home at all times.

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- Follow all NOW requirements, minimum standards for home health agencies, and state and federal rules and regulations for licensed home health agencies and nursing care.
- Comply with OCDD standards for payment, Medical Assistance Program Integrity Law (MAPIL), HIPAA, ADA, and licensing requirements.

STAFFING REQUIREMENTS

The Department of Health and Hospitals (DHH) has the responsibility to establish reasonable qualifications for providers to ensure that they are capable of providing 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 services as defined by DHH. DHH has established these staffing requirements to maintain an adequate level of quality, efficiency, and professionalism in the provision of all services in the NOW program.

Individualized and Family Support

The following exclusions apply to Individualized and Family Support services:

- Reimbursement shall not be paid for services furnished by a legally responsible relative. A legally responsible relative is defined as the parent of a minor child, foster parent, curator, tutor, legal guardian, or the recipient's spouse.
- Service may be provided by a member of the recipient's family, provided that the recipient does not live in the family member's residence and the family member is not the legally responsible relative as defined above.
- Family members who provide IFS services must meet the same standards as providers or direct care staff who are unrelated to the individual.

Residential Habilitation – Supported Independent Living

Family members who are not legally responsible relatives can be Supported Independent Living (SIL) workers provided they meet the same qualifications as any other SIL worker.

Substitute Family Care

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

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RECORD KEEPING**Components of Record Keeping**

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

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

Confidentiality and Protection of Records

Records, including administrative and recipient, must be secured against loss, tampering, destruction, or unauthorized use. Providers must comply with the confidentiality standards as set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and in Louisiana law.

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 that might identify the recipients or their families. The wrongful disclosure of such information may result in the imposition by the DHH of whatever sanctions are available pursuant to Medicaid certification authority or the imposition of a monetary fine and/or imprisonment by the United States Government pursuant to the HIPAA Privacy Rule. The information may be released only under the following conditions:

- Court order,
- Recipient's written informed consent for release of information,
- Written consent of the individual to whom the recipient's rights have been devolved when the recipient has been declared legally incompetent, or
- Written consent of the parent or legal guardian when the recipient is a minor,

A provider must, upon request, make available information in the case records to the recipient or

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legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the recipient, or reasonably likely to endanger the life or physical safety of the recipient, that information may be withheld. This determination must be documented in writing.

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

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

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

Review by State and Federal Agencies

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

Retention of Records

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

- Until records are audited and all audit questions are answered

OR

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

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

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Administrative and Personnel Files

Administrative and personnel files must be kept in accordance with all licensing requirements, the DHH Home and Community-Based Waiver Services Standards for Participation rule and Medicaid enrollment agreements.

Recipient Records

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

Recipient records and location of documents within the record must be consistent among all records. Records must be appropriately maintained so that current material can be located in the record.

The OCDD does not prescribe a specific format for documentation, but must find all components outlined below in each recipient's active record.

Organization of Records, Record Entries and Corrections

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

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

- Name of the person making the entry,
- Signature of the person making the entry,
- Functional title of the person making the entry,
- Full date of documentation, and
- Supervisor review, if required.

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

Components of Recipient Records

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

- Identifying information on the recipient that is recorded on a standardized form to include the following:
 - Name,
 - Home address,
 - Home telephone number,
 - Date of birth,
 - Sex,
 - List of current medications,
 - Primary and secondary disability,
 - Name and phone number of preferred hospital,
 - Closest living relative,
 - 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, if applicable,
 - Names, addresses, and phone numbers of other recipients or providers involved with the recipient's Plan of Care 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 services,
- Medicaid eligibility information,
- A copy of assurances of freedom of choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc. signed by the recipient,

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- Approved Plan of Care, including any revisions,
- Complete Individualized Service Plan (ISP),
- Copy of all critical incident reports, if applicable,
- Formal grievances filed by the recipient,
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified in the Service Documentation below,
- Attendance records,
- Copy of the recipient's behavior support plan, if applicable,
- Documentation of all interventions (medical, consultative, environmental and adaptive) used to ensure the recipient's health, safety, and welfare,
- Reason for case closure and any agreements with the recipient at closure,
- Copies of all pertinent correspondence,
- At least six months (or all information if services provided less than 6 months) of current pertinent information relating to services provided,

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

- Any threatening medical condition including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or any known allergies,
- Monitoring reports of waiver service providers to ensure that the services outlined in the Plan of Care are delivered as specified,
- 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 to the Plan of Care,

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- A sign-out sheet that indicates the date and signature of the person(s) who viewed the record, and
- Any other pertinent documents.

The provider must keep a separate record for each recipient being transported in the vehicle. At a minimum, this individual record should contain the following recipient information:

- Name,
- Telephone number,
- Address,
- Emergency contacts,
- Medicaid and/or Medicare insurance number and any other insurance card number,
- Current medications,
- Physician's name, telephone number and address,
- Preferred hospital,
- Current medical conditions including allergies, and
- Preferred religion (if stated).

After transportation has been provided, the recipient's transportation records must be returned to a secure, locked location in the provider agency. Recipient's transportation records must not be left in a vehicle.

Service Documentation

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

Required service documentation includes:

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- Service logs,
- Progress notes,
- Progress summaries,
- Discharge summaries for transfers and closures, and
- Individualized documentation.

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

Service Logs

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

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

- Name of recipient
- Name of provider and employee providing the service
- Service agency contact telephone number
- Date of service contact
- Start and stop time of service contact
- Place of service contact
- Purpose of service contact
 - Personal outcomes addressed
 - Other issues addressed
- Content and outcome of service contact

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

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

Services billed must clearly be related to the current Plan of Care.

Each support coordination service contact is to be briefly defined (i.e., telephone call, face-to-face visit) with a narrative in the form of a progress note. This documentation should support justification of critical support coordination elements for prior authorization of service in the Case Management Information System (CMIS).

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

Progress Notes

Progress notes must be completed by both support coordinators and direct service providers at the time of each activity or service. Progress notes summarize the recipient's day-to-day activities and demonstrate progress toward achieving his/her personal outcomes as identified in the approved Plan of Care.

NOTE: An occasional or temporary deviation from a recipient's scheduled services is acceptable as long as the services being altered are recipient-driven, person-centered and occur within the approved prior authorization. However, **when a recipient's schedule is altered on a consistent basis, a revision to the Plan of Care is required** indicating the reason for the change.

Progress notes must be of sufficient content to:

- Reflect descriptions of activities, procedures, and incidents,
- Give a picture of the service provided to the recipient,
- Show progress towards the recipient's personal outcomes,
- Record any change in the recipient's medical condition, behavior, or home situation which may indicate a need for reassessment and Plan of Care change, and

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- Reflect each entry in the service log and/or timesheet.

Checklists alone are not adequate documentation for progress notes.

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

- “Supported _____”
- “Assisted _____”
- “_____ is doing fine”
- “_____ had a good day”
- “Prepared meals”

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

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

Progress Summary

A progress summary is a synthesis of all activities for a specified period which address significant activities, progress toward the recipient’s desired personal outcomes, and changes in the recipient’s social history. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the recipient’s current Plan of Care, sufficient information for use by other support coordinators, direct service workers, or their supervisors, and evaluation of activities by program monitors. The progress summary in the service log may be used by the support coordinators and direct service providers to meet the documentation requirements.

A progress summary must be completed at least every quarter for each recipient.

Discharge Summary for Transfers and Closures

A discharge summary details the recipient’s progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a recipient’s discharge. The

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discharge summary in the service log may be used by the support coordinators and direct service providers to meet the documentation requirement.

Individualized Documentation

The support team must ensure that other documentation and data collection methods other than progress notes and progress and discharge summaries are considered so that appropriate measures are used to track the recipient's progress toward his/her goals and objectives as specified in the approved Plan of Care.

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

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

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frequency/intensity of challenging behaviors with a challenging behavior chart, and assessing for the presence of medication side-effects.

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

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

Schedule of Required Documentation

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

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SECTION 32.9: REIMBURSEMENT

REIMBURSEMENT

Providers of New Opportunities Waiver (NOW) services must utilize the Health Insurance Portability and Accountability Act compliant billing procedure code and modifier, when applicable. Refer to Appendix E for information about procedure code, unit of service and current reimbursement rates.

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

All claims for NOW services shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. (See Appendix F for claims filing information)

PROGRAM MONITORING

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

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

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

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

On-Site Reviews

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

- Ensure compliance with program requirements, and
- Ensure that services provided are appropriate to meet the needs of the recipients served.

Administrative Review

The Administrative Review includes:

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- A review of administrative records,
- A review of other provider agency documentation, and
- Provider agency staff interviews as well as interviews with a sampling of recipients to determine continued compliance with provider participation requirements.

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

Interviews

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

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

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

Personnel Record Review

The Personnel Record Review includes:

- A review of personnel files,
- A review of time sheets, and
- A review of the current organizational chart.

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Recipient Record Review

A representative sample of recipient records are reviewed to ensure the services and supports delivered to recipients are rendered according to the recipient's approved Plan of Care. 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.

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

Documentation is reviewed to ensure that the services reimbursed were

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

Provider Staff Interviews

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

- Education,
- Experience,
- Skills,
- Knowledge,
- Employment status,
- Hours worked,

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- Staff coverage,
- Supervisor to staff ratio,
- Caseload/recipient assignments,
- Supervision documentation, and
- Other applicable requirements.

Monitoring Report

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

The monitoring report includes:

- Identifying information,
- A statement of compliance with all applicable regulations or,
- Deficiencies requiring corrective action by the provider.

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

Corrective Action Report

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

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

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

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A follow-up monitoring survey will be conducted when deficiencies have been found to ensure that the provider has fully implemented the Plan of Correction. Follow up surveys may be conducted on-site or via evidence review.

Informal Dispute Resolution (Optional)

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

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

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

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

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

Fraud and Abuse

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

Quality Management

Direct service providers and support coordination agencies must have a quality enhancement process that involves:

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- Learning,
- Responding,
- Implementing, and
- Evaluating.

Agency quality enhancement activities must be reviewed and approved by the Office for Citizens with Developmental Disabilities regional waiver office, Human Services Authority or District as described in the *Quality Enhancement Provider Handbook*. (See Appendix D for information on this handbook)

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SECTION 32.11: INCIDENTS, ACCIDENTS AND COMPLAINTS

INCIDENTS, ACCIDENTS AND COMPLAINTS

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

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

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

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

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

Internal Complaint Policy

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

- Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint.
- If the complaint is verbal, the provider staff member receiving the complaint must obtain and send all pertinent information in writing to the provider complaint

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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 send a letter to the complainant acknowledging receipt of the complaint **within five working days**.
- The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the recipient, the personal representative, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution.
- The provider's administrator or designee must inform the recipient and/or the personal representative in writing **within ten working days** of receipt of the complaint, the results of the internal investigation.
- If the recipient is dissatisfied with the results of the internal investigation regarding the complaint, he/she may continue the complaint resolution process by contacting the appropriate Office for Citizens with Developmental Disabilities (OCDD) regional waiver office or Human Services Authority or District in writing, or by telephone.

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

Complainant 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 OCDD may determine when the complaint is initiated that a disclosure statement is necessary. If a Complainant Disclosure Statement is necessary, the complainant must be

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contacted and given an opportunity to withdraw the complaint.

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

Definition of Related Terms Regarding Incidents and Complaints

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

- 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 an account 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 accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (La. R.S. 40:2009.14)
- Abuse - is the infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well being is endangered. (La. R.S. 15:1503)
- 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 person's or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 15:1503)
- 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. 15:1503)
- Neglect - is the failure, by a caregiver responsible for an adult's care or by other

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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. 15:1503)

- 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. 15:1503)
- 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 classified in one of the categories listed in this section, or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the recipient or affect delivery of waiver services.

DEVELOPMENTAL DISABILITY LAW

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

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

OR

- b. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria listed above later in life that may be considered to be a developmental disability.

GLOSSARY

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

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

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

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

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

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

Appeal – A due process system of procedures which ensures that a recipient will be notified of and have an opportunity to contest a Department of Health and Hospital (DHH) decision.

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 – One or more processes used to obtain information about a person, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person requires waiver services as well as the development of the Plan of Care.

Authorized Representative – A person designated by a recipient (by use of a designation form) to act on his/her behalf with respect to his/her services.

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

Bureau of Health Services Financing (BHSF) – The Bureau within the Department of Health and Hospitals responsible for the administration of the Louisiana Medicaid Program.

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

Claim – A request for payment for services rendered.

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

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

Corrective Action Plan – Written description of action a direct service provider agency plans to take to correct deficiencies identified by the Office for Citizens with Developmental Disabilities (OCDD) or DHH.

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

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

Department of Health and Hospitals (DHH) – The state agency responsible for administering the state’s Medicaid programs and other health and related services including public health, mental health, developmental disabilities, and addictive disorder services.

Developmental Disability – See Appendix A

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

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

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

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

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

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

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

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

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation or abuse of legal or official authority.

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

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

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

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

Home and Community-Based Services (HCBS) – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the community as an alternative to institutional services to persons who meet the requirement of an institutional level of care. It provides a collection of services through an approved CMS waiver that are provided in a community setting through enrolled providers of specific Medicaid services.

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

Individualized Service Plan (ISP) – A written agreement developed by a service provider that specifies the long-range goals, short-term objectives, specific strategies or action steps, assignment of responsibility, and timeframes for meeting the recipient’s personal outcomes as specified in his/her approved Plan of Care.

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

Intermediate Care Facility for People with Developmental Disabilities (ICF/DD) – A public or private facility that provides health and habilitation services to people with developmental disabilities. ICFs/DD have four or more beds and provide “active treatment” to their residents.

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

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

Linkage – Act of connecting a recipient to a specific support coordination or service provider agency.

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

LTC – Long Term Care.

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

Medicaid Eligibility Determination (Form 90-L) – The form that is signed by a Louisiana licensed physician and used by Medicaid to establish a Level of Care (LOC). In the NOW program, a recipient must meet an ICF/DD LOC in order to be offered a waiver opportunity.

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

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

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the recipient’s activities of daily living (La. R.S.15:1503).

Monitoring – The ongoing oversight of the provision of waiver services to ensure that they are furnished according to the recipient’s Plan of Care and effectively meet his/her needs.

Multi-disciplinary Team (MDT) – The group of professionals involved in assessing the needs of a high risk recipient and making recommendations in a team staffing for services or interventions targeted at those needs.

Native Language – The language normally used by the recipient and his/her support network, which may include American or English Sign Language and other non-verbal forms of communication.

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

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

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

New Opportunities Waiver (NOW) – A 1915(c) waiver designed to provide home and community-based services to recipients who otherwise would require the level of care of an ICF/DD.

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

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

Person-Centered Planning – A Plan of Care process directed and led by the recipient or his/her authorized representative designed to identify his/her strengths, capacities, preferences, needs, and desired outcomes.

Personal Outcomes – Results achieved by or for the waiver recipient through the provision of services and supports that make a meaningful difference in the quality of his/her life.

Plan of Care – A written plan designed by the recipient, his/her authorized representative, service provider(s), and others chosen by the recipient, and facilitated by the support coordinator which lists all paid and unpaid supports and services. It also identifies broad goals and timelines identified by the recipient as necessary to achieve his/her personal outcomes.

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

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

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

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX B: GLOSSARY

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

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

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

Quality Assurance/Quality Enhancement (QA/QE) Program: - A program that assesses and improves the equity, effectiveness and efficiency of waiver services in a fiscally responsible system with a focus on the promotion and attainment of independence, inclusion, individuality and productivity of persons receiving waiver services and accomplishes these goals through standardized and comprehensive evaluations, analyses and special studies.

Quality Improvement (QI) – The performance of discovery, remediation, and quality improvement activities in order to ascertain whether the service provider agency meets assurances, corrects shortcomings, and pursues opportunities for improvement.

Quality Management – The section within the OCDD whose responsibilities include the activities to promote the provision of effective services and supports on behalf of recipients and to assure their health and welfare. Quality management activities ensure that program standards and requirements are met.

Reassessment – A core element of services defined as the process by which the baseline assessment is reviewed. It provides the opportunity to gather information for reevaluating and redesigning the overall Plan of Care.

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

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.

Request for Services Registry (RFSR) – A registry maintained by the OCDD that includes the dates of request and the names of individuals who have been determined to meet the Louisiana definition for developmental disability and wish to receive services in the NOW program.

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 (Louisiana Revised Statutes 15:1503).

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.

Single Point of Entry (SPOE) – The OCDD regional offices, Human Service Authorities and Human Service Districts where the entry point for all developmental disability services, including home and community-based waivers, is made.

SOA – Statement of Approval (previously known as a Statement of Eligibility or SOE). Statement issued by the SPOE confirming the date the individual has been determined to meet the Louisiana definition for developmental disability.

Support Coordination – Case management services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational and other support services. Activities include assessment, Plan of Care development, service monitoring, and assistance in accessing waiver, Medicaid State Plan, and other non-Medicaid services and resources.

Support Coordinator – A person who is employed by a public or private entity compensated by the State of Louisiana through Medicaid State Plan Targeted Case Management services to create and coordinate a comprehensive Plan of Care, which identifies all services and supports deemed necessary for the recipient to remain in the community as an alternative to institutionalization.

Support Team – A team comprised of the recipient, the recipient’s legal representative(s), family members, friends, support coordinator, direct service providers, medical and social work professionals as necessary, and other advocates, who assist the recipient in determining needed supports and services to meet the recipient’s identified personal outcomes. Medical and social work professionals may participate by report. All other support team members must be active recipients.

Surveillance Utilization Review System (SURS) – The program operated by the DHH Fiscal Intermediary in partnership with the Program Integrity Section, which reviews provider’s compliance with Louisiana Medicaid policies and regulations, including investigating allegations of excessive billing.

Title XIX – The section of the Social Security Act, which authorizes the Medicaid Program.

Transition – The steps or activities conducted to support the passage of the recipient from existing formal or informal services to the appropriate level of services, including disengagement from all services.

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

Waiver service – An approved service in a home and community-based waiver provided to an eligible recipient that is designed to supplement, not replace, the recipient’s natural supports.

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX C: CONTACT INFORMATION

CONTACT INFORMATION

| OFFICE NAME | TYPE OF ASSISTANCE | CONTACT INFORMATION |
|---|--|---|
| <p>Department of Health and Hospitals - Health Standards Section</p> | <p>Office to contact to report changes that affect provider license</p> | <p>Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 or (504) 342-0138 Fax: (225) 342-5292</p> |
| <p>Division of Administrative Law – Health and Hospitals Section</p> | <p>Office to contact to file an appeal request</p> | <p>Division of Administrative Law - Health and Hospitals Section P. O. Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 Fax: (225) 219-9823 Phone for oral appeals: (225) 342-5800</p> |
| <p>Provider Enrollment Section</p> | <p>Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer</p> | <p>Molina Provider Enrollment Section P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370</p> |
| <p>Provider Relations Unit</p> | <p>Office to contact to obtain assistance with questions regarding billing information</p> | <p>Molina Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783</p> |
| <p>Office of Community Services - Local Child Protection Hotline</p> | <p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a recipient under the age of 18</p> | <p>Refer to the Department of Children and Family Services website at: http://www.dss.la.gov under the “Report Child Abuse/Neglect” link</p> |
| <p>Adult Protective Services</p> | <p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a recipient age 18-59 or an emancipated minor</p> | <p>Department of Health and Hospitals Office of Aging and Adult Services 1-800-898-4910 or (225) 342-9057</p> |
| <p>Elderly Protective Services</p> | <p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of a recipient age 60 or older</p> | <p>Governor’s Office of Elderly Affairs 1-800-259-4990</p> |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX C: CONTACT INFORMATION

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| Office for Citizens with Developmental Disabilities | | |
|---|---|--|
| Office Name | Physical Address | Phone/Fax |
| Central Office | 638 N. Fourth St. Baton Rouge, LA 70802 | (225) 342-0095 1-866-783-5553 Fax (225) 342-8823 |
| Region 1 Metropolitan Human Services District | 1010 Common St, 5 th floor New Orleans, LA 70113 | (504) 599-0245 1-800-889-2975 Fax (504) 568-4660 |
| Region 2 Capital Area Human Services District | 4615 Government St., 2 nd floor Baton Rouge, LA 70806 | (225) 925-1910 1-800-768-8824 Fax (225) 925-1966 |
| Region 3 South Central Louisiana Human Services District | 690 East 1 st Street Thibodaux, LA 70301 | (985) 873-2085 1-800-861-0241 Fax (985) 449-5180 |
| Region 4 | 214 Jefferson St, Suite 301 Lafayette, LA 70501 | (337) 262-5610 1-800-648-1484 Fax (337) 262-5233 |
| Region 5 | 3501 Fifth Ave, Suite C2 Lake Charles, LA 70605 | (337) 475-8045 1-800-631-8810 |
| Region 6 | 429 Murray Street, Suite B Alexandria, LA 71301 | (318) 484-2347 1-800-640-7494 Fax (318) 484-2458 |
| Region 7 | 3018 Old Minden Rd, Suite 1211 Bossier, LA 71112 | (318) 741-7455 1-800-862-1409 Fax (318) 741-7445 |
| Region 8 | 122 St. John St., Rm. 343 Monroe, LA 71201 | (318) 362-3396 1-800-637-3113 Fax (318) 362-5306 |
| Region 9 Florida Parishes Human Services Authority | 21454 Koop Dr., Suite 2H Mandeville, LA 70471 | (985) 871-8300 1-800-866-0806 Fax (985) 871-8303 |
| Jefferson Parish Human Service Authority | 3300 W. Esplanade Ave., Suite 213 Metairie, LA 70002 | (504) 838-5357 Fax (504) 838-5400 |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX C: CONTACT INFORMATION

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| Office for Citizens with Developmental Disabilities Regional Waiver Offices | | |
|--|---|--|
| Office Name | Physical Address | Phone/Fax |
| Region 1 | 1010 Common St, 5 th floor Suite 505 New Orleans, LA 70112 | (504) 568-8564 Fax (504) 568-3373 |
| Region 2 | 4615 Government St Baton Rouge, LA 70806 | (225) 925-6286 Fax (225) 925-7080 |
| Region 3 | 690 East 1 st Street Thibodaux, LA 70301 | (985) 449-4725 Fax (985) 449-4761 |
| Region 4 | 214 Jefferson St, Suite 300 Lafayette, LA 70501 | (337) 262-1612 1-800-648-1484 Fax (337) 262-1087 |
| Region 5 | 3501 Fifth Ave, Suite C2 Lake Charles, LA 70607 | (337) 475-8085 Fax (337-472-8005 |
| Region 6 | 429 Murray Street, Suite A Alexandria, LA 71301 | (318) 484-2310 Fax (318) 484-5666 |
| Region 7 | 3018 Old Minden Rd, Suite 1211 Bossier, LA 71112 | (318) 741-7486 Fax (318) 741-7487 |
| Region 8 | 122 St. John St., Rm. 343 Monroe, LA 71201 | (318) 362-3397 1-800-637-3113 Fax (318) 362-0406 |
| Region 9 | 21454 Koop Dr., Suite 2B Mandeville, LA 70471 | (985) 871-1352 Fax (985) 871-8346 |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX D – FORMS

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FORMS

The following forms that are used in the New Opportunities Waiver Program can be accessed from the DHH website at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1564>:

- Environmental Accessibility Adaptation Job Completion Form
- Specialized Medical Equipment and Supplies Purchase and Repair Form
- Rights and Responsibilities for Individuals Requesting Home and Community-Based Waiver Services
- Transitional Expenses Planning and Approval (TEPA) Request Form
- NOW TEPA Invoice Form
- OCDD Verification of Actual TEPA Costs
- New Opportunities Waiver (NOW) – Comprehensive Plan of Care
- DHH-OCDD Revision Request Form – New Opportunity Waiver
- NOW CPOC Revision Request Form Instructions

Web Reference Information

Information for **support planning** can be obtained from the OCDD *Guidelines for Support Planning* at the following DHH website:

<http://www.dhh.louisiana.gov/offices/page.asp?ID=77&Detail=9069>

Information about **reporting critical incidents** can be obtained from the OCDD *Critical Incident Reporting for Waiver Services* at the following DHH website:

<http://www.dhh.louisiana.gov/offices/page.asp?ID=77&Detail=8421>

The *Quality Enhancement Provider Handbook* can be obtained from the DHH website at

http://www.dhh.louisiana.gov/offices/publications/pubs-191/QE_Provider_Handbook_08-01_08.pdf

A copy of the **BHSF Form 90-L** can be obtained from the following DHH website:

<http://www.dhh.louisiana.gov/offices/publications/pubs-112/90-L%20Form%20rev%2012-08.pdf>

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX E – BILLING CODES

SERVICE PROCEDURE CODES/RATES 05/30/14

| Provider Type | Proc. Code | Modifier | Waiver Service Description | HIPAA Service Description | Units/Limits |
|---------------|------------|-----------|--|---|---|
| 45 | Z0637 | | Case Management (not a waiver service) | | Monthly |
| 45 | Z0177 | | Case Management (not a waiver service) | | Monthly |
| 83 | T1005 | HQ | Center-Based Respite | Respite Care | 15 minutes \$3.19/Not to Exceed 2,880 ¼ hour units per CPOC year (exceptions granted) |
| 01 or 82 | S5125 | U1 | Individual & Family Support (IFS) - Day | Attendant Care Services | 15 minutes \$3.61 |
| 01 or 82 | S5125 | U1 and UN | IFS Shared Support, 2 persons – Day | Attendant Care Services | 15 minutes \$2.72 |
| 01 or 82 | S5125 | U1 and UP | IFS Shared Support, 3 persons - Day | Attendant Care Services | 15 minutes \$2.36 |
| 01 or 82 | S5125 | UJ | Individual & Family Support (IFS) - Night | Attendant Care Services | 15 minutes \$2.17 |
| 01 or 82 | S5125 | UN and UJ | IFS Shared Support, 2 persons - Night | Attendant Care Services | 15 minutes \$1.52 |
| 01 or 82 | S5125 | UP and UJ | IFS Shared Support, 3 persons - Night | Attendant Care Services | 15 minutes \$1.29 |
| 89 | S5136 | | Supervised Independent Living (SIL) | Companion Care | Day \$16.93 |
| 82 or 89 | T2025 | | Community Integration & Development | Waiver Services | 15 minutes \$3.31/NTE 240 ¼ hour units per CPOC year in combination with T2025 UN and T2025 UP |
| 82 or 89 | T2025 | UN | Community Integration & Development, 2 persons | Waiver Services | 15 minutes \$1.89/NTE 240 ¼ hour units per CPOC year in combination with T2025 and T2025 UP |
| 82 or 89 | T2025 | UP | Community Integration & Development, 3 persons | Waiver Services | 15 minutes \$1.42/NTE 240 ¼ hour units per CPOC year in combination with T2025 and T2025 UN |
| 84 | S5140 | | Substitute Family Care (SFC) | Foster Care, Adult | Day \$18.91 |
| 14 | T2021 | | Day Habilitation | Day Habilitation | 15 minutes \$1.66/Minimum of 16 ¼ hour units NTE maximum of 32 ¼ hour units per day and 8,320 ¼ hour units per CPOC year |
| 14 | T2003 | HB, U6 | Day Habilitation Non-Emergency Transportation | Non-Emergency Transportation | Day (one-way) \$5.67/NTE 2 one-way trips per day |
| 14 | A0130 | HB, U6 | Day Habilitation Non-Emergency Transportation - wheelchair | Non-Emergency Transportation - wheelchair | Day (one-way) \$9.46/NTE 2 one-way trips per day |
| 44 | T1002 | | RN Services | RN Services | 15 minutes \$8.33 |
| 44 | T1002 | UN | RN Services, 2 persons | RN Services, 2 persons | 15 minutes \$6.25 |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX E – BILLING CODES

| Provider Type | Proc. Code | Modifier | Waiver Service Description | HIPAA Service Description | Units/Limits |
|---------------|------------|----------|--|--------------------------------------|--|
| 44 | T1002 | UP | RN Services, 3 persons | RN Services, 3 persons | 15 minutes \$5.50 |
| 44 | T1003 | | LPN/LVN Services | LPN/LVN Services | 15 minutes \$7.84 |
| 44 | T1003 | UN | LPN/LVN Services, 2 persons | LPN/LVN Services | 15 minutes \$5.88 |
| 44 | T1003 | UP | LPN/LVN Services, 3 persons | LPN/LVN Services | 15 minutes \$5.17 |
| 44,82,89 | H2017 | U7 | Professional Services - Psychologist | Psychosocial Rehabilitation Services | 15 minutes \$29.55/NTE \$2,250 per CPOC year in combination with H2017 AJ and H2017 AE (exceptions granted) |
| 44,82,89 | H2017 | AJ | Professional Services - Social Worker | Psychosocial Rehabilitation Services | 15 minutes \$9.19/NTE \$2,250 per CPOC year in combination with H2017 U7 and H2017 AE (exceptions granted) |
| 44,82,89 | H2017 | AE | Nutrition/Dietary Services | Psychosocial Rehabilitation Services | 15 minutes \$8.82/NTE \$2,250 per CPOC year in combination with H2017 AJ and H2017 U7 (exceptions granted) |
| 15 | Z0616 | | Environmental Access. (Ramp) | Environmental Access. (Ramp) | \$7,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient may access another \$7,000.00 |
| 15 | Z0617 | | Environmental Access. (Lift) | Environmental Access. (Lift) | |
| 15 | Z0618 | | Environmental Access. (Bathroom) | Environmental Access. (Bathroom) | |
| 15 | Z0620 | | Environmental Access. (Other) | Environmental Access. (Other) | |
| 17 | Z0621 | | Medical Equip. & Supplies (lifts) | Medical Equip. & Supplies (lifts) | \$1,000.00 per recipient; once the recipient reaches 90% or greater of the cap and the account has been dormant for 3 years, the recipient may access another \$1,000 |
| 17 | Z0622 | | Medical Equip. & Supplies (switches) | Medical Equip. & Supplies (switches) | |
| 17 | Z0623 | | Medical Equip. & Supplies (controls) | Medical Equip. & Supplies (controls) | |
| 17 | Z0624 | | Medical Equip. & Supplies (other) | Medical Equip. & Supplies (other) | |
| 17 | T2029 | RP | Medical Equip. & Supplies (routine maintenance & repair) | | |
| 13 | T2019 | | Employment Related Training | Habilitation, Supported Employment | 15 minutes \$1.66/Minimum of 16 ¼ hour units NTE maximum of 32 ¼ hour units per day and 8,320 ¼ hour units per CPOC year. |
| 98 | H2023 | | Supported Employment – one on one | Supported Employment | 15 minutes \$6.66/Not to Exceed 1,280 ¼ hour units per CPOC year |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX E – BILLING CODES

| Provider Type | Proc. Code | Modifier | Waiver Service Description | HIPAA Service Description | Units/Limits |
|---------------|------------|----------|---|---|---|
| 98 | H2026 | | Supported Employment – follow along | Ongoing Support to Maintain Employment | Day \$49.18/Not to Exceed 24 days per CPOC year |
| 98 | H2025 | TT | Supported Employment – mobile crew | Ongoing Support to Maintain Employment | 15 minutes \$2.01/Not to Exceed 8,320 ¼ hour units per CPOC year |
| 14 | T2003 | HB | Supported Employment Non-Emergency Transportation | Non-Emergency Transportation | Day (one-way) \$5.67/Not to Exceed 2 one-way trips per day |
| 14 | A0130 | HB | Supported Employment Non-Emergency Transportation -wheelchair | Non-Emergency Transportation - wheelchair | Day (one-way) \$9.46/Not to Exceed 2 one-way trips per day |
| 02 | T2038 | | One Time Transitional Service | Community Transition, Waiver | Lifetime \$3,000.00 |
| 16 | S5160 | | PERS (Install & Test) | PER (Install & Test) | Initial installation \$30.00 |
| 16 | S5161 | | PERS (Maintenance) | PER (Maintenance) | Monthly \$27.00 |
| AW | Z0648 | Z0648 | Housing Stabilization | Permanent Supportive Housing | 15 minutes - \$15.11 1 hour - \$60.44 |
| AW | Z0649 | Z0649 | Housing Stabilization Transition | Permanent Supportive Housing | 15 minutes - \$15.11 1 hour - \$60.44. |

NTE = Not to Exceed

Modifiers

Certain procedure codes will require a modifier (or modifiers) in order to distinguish services. The following modifiers are applicable to New Opportunities Waiver (NOW) providers:

- AJ = Licensed Social Worker
- HB = Adult Program, Transportation
- HQ = Group Setting
- TD = Registered Nurse (RN)
- TE = Licensed Practical Nurse (LPN)
- TT = Individual Service Provided to More than One Person
- U1 = Day
- U6 = Day Habilitation
- U7 = Psychologist
- UJ = Night
- UN = 2 people
- UP = 3 people

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

CLAIMS FILING

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

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

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

Paper claims should be submitted to:

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

Services may be billed using:

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

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

This appendix includes the following:

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

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

CMS 1500 (02/12) INSTRUCTIONS FOR HOME AND COMMUNITY – BASED WAIVER SERVICES

| Locator # | Description | Instructions | Alerts |
|-----------|---|--|--|
| 1 | Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung | Required -- Enter an "X" in the box marked Medicaid (Medicaid #). | You must write "WAIVER" at the top center of the Louisiana Medicaid claim form. |
| 1a | Insured's I.D. Number | Required – Enter the recipient's 13-digit Medicaid I.D. number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. NOTE: The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient's name in Block 2. | |
| 2 | Patient's Name | Required – Enter the recipient's last name, first name, middle initial. | |
| 3 | Patient's Birth Date Sex | Situational – Enter the recipient's date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient. | |
| 4 | Insured's Name | Situational – Complete correctly if the recipient has other insurance; otherwise, leave blank. | |
| 5 | Patient's Address | Optional – Print the recipient's permanent address. | |
| 6 | Patient Relationship to Insured | Situational – Complete if appropriate or leave blank. | |
| 7 | Insured's Address | Situational – Complete if appropriate or leave blank. | |
| 8 | RESERVED FOR NUCC USE | | |
| 9 | Other Insured's Name | Situational – Complete if appropriate or leave blank. | |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|---|--|--|
| 9a | Other Insured's Policy or Group Number | <p>Situational – If recipient has no other coverage, leave blank.</p> <p>If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is required in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number.</p> <p>Make sure the EOB or EOBs from other insurance(s) are attached to the claim.</p> | <p>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</p> |
| 9b | RESERVED FOR NUCC USE | Leave Blank. | |
| 9c | RESERVED FOR NUCC USE | Leave Blank. | |
| 9d | Insurance Plan Name or Program Name | Situational – Complete if appropriate or leave blank. | |
| 10 | Is Patient's Condition Related To: | Situational – Complete if appropriate or leave blank. | |
| 11 | Insured's Policy Group or FECA Number | Situational – Complete if appropriate or leave blank. | |
| 11a | Insured's Date of Birth Sex | Situational – Complete if appropriate or leave blank. | |
| 11b | OTHER CLAIM ID (Designated by NUCC) | Leave Blank. | |
| 11c | Insurance Plan Name or Program Name | Situational – Complete if appropriate or leave blank. | |
| 11d | Is There Another Health Benefit Plan? | Situational – Complete if appropriate or leave blank. | |
| 12 | Patient's or Authorized Person's Signature (Release of Records) | Situational – Complete if appropriate or leave blank. | |
| 13 | Insured's or Authorized Person's Signature (Payment) | Situational – Obtain signature if appropriate or leave blank. | |
| 14 | Date of Current Illness / Injury / Pregnancy | Optional. | |
| 15 | OTHER DATE | Leave Blank. | |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|---|--|---|
| 16 | Dates Patient Unable to Work in Current Occupation | Optional. | |
| 17 | Name of Referring Provider or Other Source | Situational – Complete if applicable. | |
| 17a | Unlabeled | Situational – Complete if applicable. | |
| 17b | NPI | Situational – Complete if applicable. | |
| 18 | Hospitalization Dates Related to Current Services | Optional. | |
| 19 | ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | Leave Blank. | |
| 20 | Outside Lab? | Optional. | |
| 21 | <p>ICD Indicator</p> <p>Diagnosis or Nature of Illness or Injury</p> | <p>Required – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p>Required – Enter the most current ICD diagnosis code.</p> <p>NOTE: The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p> | <p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>ICD-9 diagnosis codes must be used on claims for dates of service prior to 10/1/15.</p> <p>ICD-10- codes must be used on claims for dates of service on or after 10/1/15.</p> <p>Refer to the provider notice concerning the federally required implementation of ICD-10 coding which is posted on the ICD-10 Tab at the top of the Home page at (www.lamedicaid.com)</p> |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|-----------------------------------|--|--|
| 22 | Resubmission Code | <p>Situational. If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>VOIDS</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p> | <p>Effective with date of processing 5/19/14, providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).</p> <p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.</p> |
| 23 | Prior Authorization (PA) Number | Required – Enter the 9-Digit PA number in this field. | |
| 24 | Supplemental Information | Situational | |
| 24A | Date(s) of Service | <p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.</p> | |
| 24B | Place of Service | Required -- Enter the appropriate place of service code for the services rendered. | |
| 24C | EMG | Leave Blank. | |
| 24D | Procedures, Services, or Supplies | <p>Required -- Enter the procedure code(s) for services rendered in the un-shaded area(s).</p> <p>If a modifier(s) is required, enter the appropriate modifier in the correct field.</p> | |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|---------------------------|---|--|
| 24E | Diagnosis Pointer | Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter (“A”, “B”, etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code. | |
| 24F | Amount Charged | Required -- Enter usual and customary charges for the service rendered. | |
| 24G | Days or Units | Required -- Enter the number of units billed for the procedure code entered on the same line in 24D | |
| 24H | EPSDT Family Plan | Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral. | |
| 24I | I.D. Qual. | Optional. If possible, leave blank for Louisiana Medicaid billing. | |
| 24J | Rendering Provider I.D. # | Situational – If appropriate, entering the Rendering Provider’s 7-digit Medicaid Provider Number in the shaded portion of the block is required . Entering the Rendering Provider’s NPI in the non-shaded portion of the block is optional . | In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required. |
| 25 | Federal Tax I.D. Number | Optional. | |
| 26 | Patient’s Account No. | Situational – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters. | |
| 27 | Accept Assignment? | Optional. Claim filing acknowledges acceptance of Medicaid assignment. | |
| 28 | Total Charge | Required – Enter the total of all charges listed on the claim. | |
| 29 | Amount Paid | Situational – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter ‘0’ if the third party did not pay. If TPL does not apply to the claim, leave blank. | |

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

| Locator # | Description | Instructions | Alerts |
|-----------|---|--|---|
| 30 | Reserved for NUCC use | Leave Blank. | |
| 31 | Signature of Physician or Supplier Including Degrees or Credentials Date | Optional -- The practitioner or the practitioner's authorized representative's original signature is no longer required. Required -- Enter the date of the signature. | |
| 32 | Service Facility Location Information | Situational – Complete as appropriate or leave blank. | |
| 32a | NPI | Optional . | |
| 32b | Unlabeled | Situational – Complete if appropriate or leave blank. | |
| 33 | Billing Provider Info & Phone # | Required -- Enter the provider name, address including zip code and telephone number. | |
| 33a | NPI | Optional . | |
| 33b | Unlabeled | Required – Enter the billing provider's 7-digit Medicaid ID number. ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing. | The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims. |

REMINDER: MAKE SURE “WAIVER” IS WRITTEN IN BOLD, LEGIBLE LETTERS AT THE TOP CENTER OF THE CLAIM FORM

Sample forms are on the following pages

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM WITH ICD-9 DIAGNOSIS CODE
(DATES BEFORE 10/1/15)



WAIVER

HEALTH INSURANCE CLAIM FORM

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

| | | | |
|---|--|--|--|
| PICA | | PICA | |
| 1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK/LUNG (ID#) OTHER (ID#) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123 | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS | | 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M X F) 07 31 72 M X F | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? (PLACE (State) IN _____) c. OTHER ACCIDENT? YES NO | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F) b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL | | 15. OTHER DATE (MM DD YY) QUAL | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? YES NO \$ CHARGES | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. 3510 B. C. D. E. F. G. H. I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER 4123123123 | |
| 24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. I. ID. QUAL J. RENDERING PROVIDER ID. # | | | |
| 1 03 31 14 03 31 14 12 S5125 UN A 90 00 30 NPI | | | |
| 2 04 02 14 04 02 14 12 S5125 UN A 75 00 25 NPI | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | 26. PATIENT'S ACCOUNT NO. 27. ACCEPT AS SIGNMENT? (For govt. claims, see back) X YES NO | |
| 28. TOTAL CHARGE \$ 165 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ | | 33. BILLING PROVIDER INFO & PH# (225) 555-4957 | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe DATE 4/5/14 | | 32. SERVICE FACILITY LOCATION INFORMATION Here For You Waiver 200 Main St Any Town, LA 70000 a. 1239876543 b. 1239876 | |

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)



WAIVER

HEALTH INSURANCE CLAIM FORM

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

| | | | |
|--|--|---|--|
| 1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK/LUNG (ID#) OTHER (ID#) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS | | 3. PATIENT'S BIRTH DATE (MM DD YY) 07 31 72 SEX M X F | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code) | | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. RESERVED FOR NUCC USE | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL | | 15. OTHER DATE MM DD YY QUAL | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. G5 10 B. C. D. E. F. G. H. I. J. K. L. | | 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER Prior Auth # | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. I.D. ID. QUAL. J. RENDERING PROVIDER ID. # | | 20. OUTSIDE LAB? \$ CHARGES YES NO 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For g04, date, see back) X YES NO 28. TOTAL CHARGE \$ 165 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 165 00 | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Ima Biller DATE 10/15/15 | | 32. SERVICE FACILITY LOCATION INFORMATION a. b. 33. BILLING PROVIDER INFO & PH# (225) 555-4957 HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000 a. 123967654 b. 1239876 | |

EXAMPLE OF ICD 10

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

ADJUSTING/VOIDING CLAIMS

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

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

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

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

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

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

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

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

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

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING**PAGE(S) 14**

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

When the void claim is approved, it will be listed under the "Void" column of the RA.

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

Sample forms are on the following pages.

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-9 DIAGNOSIS CODE
(DATES BEFORE 10/01/15)



WAIVER

HEALTH INSURANCE CLAIM FORM

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--------------------|--|--|--|--|--------------------|--|--|--|--|
| PICA | | | | | | | | | | PICA | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK/LUNG OTHER (Medicare #) X (Medicaid #) (ID#DoD#) (Member ID#) (ID#) (ID#) | | | | | | | | | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123 | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 | | | | | SEX M X F | | | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | | | | | 7. INSURED'S ADDRESS (No., Street) CITY STATE | | | | | | | | | | | | | | | | | | | |
| ZIP CODE TELEPHONE (Include Area Code) () | | | | | | | | | | 8. RESERVED FOR NUCC USE | | | | | | | | | | ZIP CODE TELEPHONE (Include Area Code) () | | | | | | | | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT? YES NO | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED | | | | | | | | | | | | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL | | | | | | | | | | 15. OTHER DATE QUAL MM DD YY | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. 3510 B. C. D. E. F. G. H. I. J. K. L. | | | | | | | | | | 22. RESUBMISSION CODE ORIGINAL REF. NO. A 00 4094198765400 | | | | | 23. PRIOR AUTHORIZATION NUMBER 4123123123 | | | | | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OF UNITS H. (PRO) Fwy Plw I. ID. QUAL J. RENDERING PROVIDER ID. # | | | | | | | | | | 1 03 31 14 03 31 14 12 S5125 UN A 75 00 25 NPI | | | | | | | | | | 2 NPI | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | | | | | | | | | 26. PATIENT'S ACCOUNT NO. | | | | | 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) X YES NO | | | | | 28. TOTAL CHARGE \$ 75 00 | | | | | 29. AMOUNT PAID \$ | | | | | 30. BALANCE DUE \$ | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) SIGNED Jane Doe DATE 4/9/14 | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | 33. BILLING PROVIDER INFO & PH# (225) 555-4957 Here For You Waiver 200 Main St Any Town, LA 70000 a. 1239876543 b. 1239876 | | | | | | | | | | | | | | |

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CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM ADJUSTMENT WITH ICD-10 DIAGNOSIS CODE
(DATES ON OR AFTER 10/01/15)



WAIVER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0212

| | | | |
|--|--|--|--|
| <input type="checkbox"/> PICA | | <input type="checkbox"/> PICA | |
| 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA ELK/LUNG OTHER (Medicare #) (Medicaid #) (IDM/DoD#) (Member ID#) (ID#) (ID#) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123 | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS | | 3. PATIENT'S BIRTH DATE SEX 07 31 72 M X F | |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | 5. PATIENT'S ADDRESS (No., Street) | |
| 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other | | 7. INSURED'S ADDRESS (No., Street) | |
| CITY STATE | | CITY STATE | |
| ZIP CODE TELEPHONE (include Area Code) | | ZIP CODE TELEPHONE (include Area Code) | |
| 8. RESERVED FOR NUCC USE | | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 10. IS PATIENT'S CONDITION RELATED TO: | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER TPL Code if applicable | | a. EMPLOYMENT? (Current or Previous) YES NO | |
| b. RESERVED FOR NUCC USE | | b. AUTO ACCIDENT? PLACE (State) | |
| c. RESERVED FOR NUCC USE | | c. OTHER ACCIDENT? | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. RESERVED FOR LOCAL USE | |
| READ BACK OF FORM BEFORE SIGNING THIS FORM. | | If yes, complete items 9, 9a and 9d. | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize release of my medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | |
| SIGNED DATE | | SIGNED | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) | | 15. OTHER DATE | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? \$ CHARGES | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD-10 0 | | 22. RE-SUBMISSION CODE ORIGINAL REF. NO. | |
| A. G510 B. C. D. | | A02 5299198798700 | |
| E. F. G. H. | | 23. PRIOR AUTHORIZATION NUMBER | |
| I. J. K. L. | | Prior Auth# | |
| 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. SPOT FEE I. ID. QUAL. J. RENDERING PROVIDER ID.# | | 1 10 08 15 10 08 15 12 S5125 UN A 90 00 30 NPI | |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | | 26. PATIENT'S ACCOUNT NO. | |
| 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) | | 28. TOTAL CHARGE | |
| X YES NO | | 29. AMOUNT PAID | |
| 30. BALANCE DUE | | 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | |
| 32. SERVICE FACILITY LOCATION INFORMATION | | 33. BILLING PROVIDER INFO & PH# (225) 555-4957 | |
| SIGNED Ima Biller DATE 10/15/15 | | HERE FOR YOU WAIVER 200 MAIN ST ANY TOWN, LA 70000 | |
| a. 123967654 b. 1239876 | | a. 123967654 b. 1239876 | |

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APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CHAPTER 32: NEW OPPORTUNITIES WAIVER

APPENDIX F – CLAIMS FILING

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

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

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

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